UNIVERSITY OF ALBERTA

THE EXPERIENCES OF FILIPINO-CANADIAN PATIENTS: "ONE OF US" (*HINDI IBANG TAO*) AND "NOT ONE OF US" (*IBANG TAO*)

by

Alberta Catherine Y. Pasco

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ABSTRACT

With the use of observation, field notes, interviews, and a personal diary, the author used *focused ethnography* to uncover culturally-embedded values that implicitly guide Filipino-Canadian patients' interactions with Canadian nurses and are integral to the developing patient-nurse relationship. A purposive sampling of 23 Filipino-Canadian patients who received care in Canadian hospitals participated. The findings generally reflect the personalistic worldview of Filipinos, which fosters interactions of warmth, intimacy, security of kinship, and friendship. The family remained basic unit of social organization among Filipino-Canadians and serves as the major source of support, especially during illness, birth or death. The "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) delineation emerged very distinctly and permeated the Filipino-Canadian patients' prerogative of who performs tasks or receives information that they consider "personal" and "private." The urgency of the patients' conditions, the intimacy required for most nursing procedures, and short hospitalizations meant that patients must interact without going through the initial levels of formality (*pakikitungo*), adjusting (*pakikibagay*), and acceptance (*pakikisama*) under the "not one of us" relationship. Almost immediately, they move to the subsequent levels of mutual comfort (*pakikipagpalagayang-loob*) and/or oneness (*pakikiisa*) under the "one of us" relationship. The willingness of the patient to trust determines whether the nurses from the same or other cultures are "one of us." In addition, it is the patient's perceptions of the nurse's ability to share their worldview of *kapwa*—the Filipinos' core value embodied in how they relate with

other humans their "beings" (*pakikipagkapwa-tao*)—that allows the patient and the nurse to progress in these levels of interaction and therefore become "one of us."

Also revealed was the distinction that "one of us" are supposed to "watch over" them (*bantay*), whereas "not one of us" are expected to "care for" them (*alaga*). Kindness, respect, courtesy, being approachable, and willingness to accommodate were important qualities sought by Filipino-Canadian patients from nurses regardless of whether they are from the same or from other cultures. The experiences of Filipino-Canadian patients encompassed physiological, psychosocial, and spiritual dimensions. Communication is a key factor in the patient-nurse interaction. Nurses and other health professionals must understand the Filipino-Canadians' languages of words, gaze, touch, and food in order to facilitate an optimal patient-nurse relationship.

DEDICATION

To my parents and siblings who were always there for me as a loving family.

To Dad who encouraged me to become a nurse.

To Mom who showed me how to care.

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CHAPTER 1

INTRODUCTION

With an increase in the overall number of Canadian immigrants and shifts in the immigrants' countries of origin over the past several decades, there has been a growing appreciation of diversity within Canada and an increased awareness of the complex issues and problems in the health care system in general and, more particularly, in the practice of nursing. Alongside these changing trends are the pressures of rapid globalization, which continually challenge Canadian nurses and other health professionals to offer culturally specific and competent nursing care. In addition to understanding the distinct culture of Canada's First Nations population, nurses must open themselves to and accommodate the cultures of immigrant populations.

Nurses constitute the largest work force in the delivery of health care in Canada. However, little has been written concerning how Canadian nurses assess, plan, implement, and evaluate culturally specific and competent nursing care. If health care needs and practices of culturally diverse immigrants differ from those of mainstream Canadians, nurses and other health professionals need to know and understand not only their own cultural matrix of beliefs and practices but also those of the immigrants for whom they care. Little is known, however, about the culture and health care needs of immigrant populations. Furthermore, very few studies have described the experiences of nursing care as perceived by patients who come from different cultural groups.

As a discipline, nursing focuses on developing knowledge concerning how individuals and communities achieve health within the unique and complex environments where nurses work. The four aspects around which nursing knowledge develops—persons, health, nursing, and environment—have yet to be explored among the Filipino immigrants living in Canada. The descriptive nature of qualitative research will make explicit facets of these four aspects, which have profound implications not only in the development of knowledge for the discipline of nursing but also in the practice of nursing.

Statement of the Problem

In the initial stages of conceptualizing this study, I contacted several hospitals in one of the largest cities in the western side of Canada to determine how many Filipino-Canadians were admitted each month. None of the hospitals, however, kept such information in their records. In fact, the admission form did not include a space for the patient's country of origin. An administrator on site explained that in some situations, this information was considered sensitive and has therefore been covered by the 1996 Freedom of Information and Protection of Privacy Act. She noted, however, that if cultural difficulties were encountered, the assistance of a cultural broker was sought.

When I asked if I could speak to a cultural broker for Filipino-Canadian patients, I was told that the hospital did not have one because Filipinos were likely to speak and understand the English language better than other immigrants to Canada. I was also informed that, in most instances, if the Filipino-Canadian patient did not speak or understand English, a member of the family was able to act as a translator or

interpreter. This information left some questions unanswered: What happens, for instance, if the Filipino-Canadian patient lived alone or did not have any relatives in Canada? Were Filipino-Canadian patients asked whether they needed a cultural broker, or did the hospital administrators/staff merely assume that because Filipinos speak English better than most immigrants from other countries do, they can manage without one? Was language the only criterion used when determining whether assistance was needed? If so, why were there instances when nurses and patients spoke about the same thing and used the same words yet did not seem to understand one another? Did this imply that there was more to consider when listening to what was said? Should this type of misunderstanding be construed as a mere difficulty in interpretation or translation, or does the issue go far beyond language differences? These initial contacts with hospital administrators helped me to focus on areas I needed to cover in this study.

This incident brought to mind McGee's (1992) experience concerning her mother's admission to hospital for a routine operation. The nurse in the ward arranged for her to have a bed in the same bay as some Asian women and ordered her a curry dish for lunch. She claimed that the nurse mistook her mother for an Asian after seeing her "obviously foreign name on the admissions list" (p. xi). This author said that she is not, in terms of ethnic origin, English, although her parents emigrated to England from the Irish Republic and they had lived in Britain for many years. She attributed the mistake to "the stereotypical thinking that everyone with a strange name must be Asian" (p. xi) yet conceded that she also knew little about other cultures.

This incident made me wonder whether the problem was due in part to patients' not being asked during admission their country of origin and length of time in Canada. As a nurse, McGee accepted that her own patients came from different cultural backgrounds, but neither she nor her colleagues knew very much about the cultures of these patients. Because they had no understanding of their patients' cultures except for information gathered directly from patients and their families in what she described as a "haphazard 'do this' or 'don't do that' basis" (p. xi), she and her colleagues were exasperated over what they interpreted as "awkwardness." The inadequacies of the nursing staff were even more evident when their patients did not speak English. Concerns such as who could translate for them and whether they fully understood their illnesses and their treatments could interfere with their nursing care. McGee also commented on how, in the 1980s, she found that no time was given to prepare nursing students to care for patients from different cultures, little published material dealing with this concern existed, there were few people who could advise the nurses, and there was no convenient access to the limited printed resources available. These are still some of the gaps in nursing knowledge, practice, and research. There remains an urgent need to study the patients' experiences of being cared for by nurses from other cultures within a multicultural context. In this study, the following question guided the research: What were the Filipino-Canadian patients' experiences of being cared for by nurses from other cultures?

Purpose of the Study

The purpose of this study was to uncover culturally-embedded values that implicitly guide Filipino-Canadian patients' ways of behaving toward and relating to nurses from other cultures within a multicultural context of Canada and to draw from them concepts that will improve the quality of nursing care across cultures. Through the method of focused ethnography, I was particularly interested in identifying the underlying beliefs, values, and practices that distinguish Filipino-Canadian patients from other Canadians and describing behavioral responses and patterns of relating so that the provision of health care may be culturally specific and competent.

In other words, the intent was to make explicit what is implicit within the Philippine culture (Germain, 1986). Such cultural knowledge requires an understanding of Filipinos—what they do, what they say, how they relate with one another, what their customs and beliefs are, and how they derive meaning from their experiences (Goetz & LeCompte, 1984; Spradley, 1980; Spradley & McCurdy, 1972; Van Maanen, 1995). It involved an ongoing attempt to place specific encounters, events, and understandings into a fuller, more meaningful context (Tedlock, 2000).

The study took place in a large city located in western Canada. The findings of this study were compared and contrasted with existing literature on Filipinos living in the United States and those in the Philippines. Appendix 1 contains a glossary of Filipino terms.

CHAPTER 2

REVIEW OF RELATED LITERATURE

Culture as Defined in the Literature

Although culture has been defined in many ways, there is agreement that culture is learned, shared, and passed on from one generation to the next (Leininger, 1977; Lipson, Dibble, & Minarik, 1996; Macgregor, 1967; Smith, 1980). There is less agreement, however, on whether all aspects of living have cultural components or if various facets of culture are interrelated. Brink (1976), for example, stated that whatever a person believes to be true or right about any aspect of life probably stems from culture, but how do we know whether certain aspects of life stem from culture or are mere idiosyncrasies? Of course, in each culture, there is a characteristic way of life within which the individual acquires a language, food habits, religious beliefs and practices, a style of dressing, and other subtle characteristics, such as how one responds to pain or reacts to fear. All of these distinguish a member of one culture from that of another, but there seems to be less clarity about what stems from culture and what is merely individual idiosyncrasy.

Some definitions of culture underscore the word *pattern*. Leininger (1977) defined culture as "values, beliefs, norms, and life ways of a particular group that guide their thinking, decisions, [and] actions in *patterned ways*" (emphasis is mine). Another definition is Smith's (1980): "Culture is a set of customs, beliefs, traditions, and values that provide the *pattern* for the human definition of life situations." The common patterns that exist within a given culture define the boundaries of different groups, yet even within a specific cultural group, variances exist based on the degree

of assimilation into the mainstream culture (Giger & Davidhizar, 1991; Leininger, 1977). Regardless of the existing ideological tensions between assimilation and pluralism concerning health care beliefs and practices, there is an increased recognition that diversity is a right of individuals and groups. Yet, many aspects of treatment and care imply the expectation that health-seeking behaviors comply with the mainstream culture as generally reflected in the Western biomedical health care system (Kavanagh, Absalom, Beil, & Schliessmann, 1999).

Acculturation or Assimilation

The process of *acculturation* is described as involuntary, in that the members of a cultural group are forced to learn the new culture to survive. It refers to cultural and behavioral assimilation, and can be defined as the conforming of one's cultural patterns to those of the host society. Acculturation also can be referred to as "*assimilation*—the process by which an individual develops a new cultural identity" (Spector, 2000). Assimilation is understood to mean the blending of cultures and structures into a dominant entity, eventually resulting in the disappearance of differences from the mainstream society (McLemore, 1994). It is assumed that the process of acculturation usually takes three generations. Thus, in the United States, an adult grandchild of an immigrant is considered fully Americanized.

Models of Assimilation

There are several models for the process of assimilation, namely "conformity," "melting pot," "cultural pluralism," "multiculturalism," and "cosmopolitanism." Canadian culture, however, is described as a "mosaic."

Mosaic

Mosaic means that there is no official culture—all cultural groups are equal in status. In the words of the Honorable Perrin Beatty (1989, p. 38), a former Minister of National Health and Welfare, "Our children must understand that we are different from the United States because we choose not to be a melting pot, because we choose to be a mosaic."[1] Although Canada adopted a cultural mosaic model by the passage of the 1971 multiculturalism policy and the 1988 national multiculturalism law, its ideology was not viewed as preventing the interracial tensions experienced in neighboring countries, such as the United States. The rationale, therefore, for this law was to preserve and enhance multiculturalism in Canada, to reduce discrimination, to enhance multicultural awareness, and to promote institutional change that exemplifies cultural sensitivity at the federal level. This implied that (a) racial and cultural equality is now protected by law and (b) recognition of diversity has become a permanent aspect of Canadian society (Fleras and Elliott, 1992).

Conformity

McLemore (1994) defined *conformity* as the acceptance and the blending of a dominant culture into another culture's values and norms, as in the expression A+B+C=A. In the United States, for example, culturally diverse individuals are expected to assimilate and to adopt the Anglo-American view of care-cure (Ferguson & Browne, 1991). Those who believe in mainstream Anglo-American cultural values rely heavily on the medical and nursing expertise offered by the health care system.

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[1] Opening address delivered in the First National Conference on Multiculturalism and Health Care: Realities and Needs, held in Toronto, Canada, on March 31, 1989.

Melting Pot

Melting pot means the merging of two or more cultures resulting in the creation of one unlike any of those contributing to the composite, as in the formulation A+B+C=D (McLemore, 1994). The Philippines, for example, was known as the melting pot in Asia because among all other Asian countries, it had the greatest influence from its neighboring countries, such as China, Malaysia, Indonesia, and Japan, and from its Spanish and American colonizers, and yet Filipinos have a culture of their own.

Cultural Pluralism

According to McLemore (1994), *cultural pluralism* is a model of assimilation by addition: A+B+C=A+B+C. The essence of cultural pluralism is the peaceful coexistence of various racial and ethnic groups, with each retaining its own subculture (Thio, 1986). In the case of two cultures (that is, biculturalism and bilingualism), cultural pluralism suggests an acceptance of a shared public culture but greater separation and diversity in the "ethnic," private sphere.

Multiculturalism

Multiculturalism is another model of assimilation that recognizes multiple sources of culture and promotes sensitivity to diversity. This diversity goes beyond typical group classifications to include various configurations of acculturation and assimilation, interpretations of history, cultural beliefs, and lifestyles (Bennett, 1995; Hollinger, 1995).

Within Canada, multiculturalism reflects a tolerance and respect for the beliefs and cultural traditions of Canadians who come from diverse cultural backgrounds. Fleras and Elliott (1992) defined multiculturalism as "an official

doctrine and corresponding set of policies and practices in which ethno-racial differences are formally promoted and incorporated as an integral component of the political, social and symbolic order" (p. 22). They perceived this definition on a multidimensional level (a) in a descriptive way that recognizes and describes the diversity of society; (b) in a prescriptive way that advocates the ideas and ideals of diversity; (c) within a political perspective that emphasizes policies about diversity, or (d) as intergroup dynamics, the process by which various ethnic groups interact. Kulig (1995) also suggested viewing multiculturalism at (a) the individual level, where members of a cultural group are confident and able to relate to others who are culturally different; (b) the group level, as the sorting out of cultural differences and maintenance of a group's heritage; (c) the institutional level, entailing the restructuring of organizations so that they are receptive to, and representative of, diversity; and (d) the societal level, characterized by a harmonious coexistence of cultural traditions. She stressed that multiculturalism refers not only to diet, dance, and dialect; it also includes eliminating the barriers within institutions, providing equal access and opportunities, and considering cultural diversity needs in decision-making processes and in distribution of resource.

Cosmopolitanism

Hollinger (1995) used another term, *cosmopolitanism*, to refer to the element of the multiculturalism movement that cuts against pluralism by promoting multiple identities and emphasizing the changing characters of groups. It is contrary to pluralism in the sense that cosmopolitanism supports voluntarily revised affiliations and is less supportive of traditional boundaries (Kavanagh et al., 1999).

Heterogeneity Among Filipinos

Efforts to identify key concepts for defining a Filipino national character have met with limited success, in part because of Filipinos' refusal to be stereotyped and reluctance to be identified with the cultural mainstream, particularly because of their own heterogeneity. Three major, interrelated factors have been identified to explain such heterogeneity (Orque, Bloch, & Monrroy, 1983). The first is the fragmented geographical nature of the Philippines, which has led to a marked regionalism. The Igorots of the North, for example, have ways that are quite distinct from the Tagalogs of Central Luzon and the Maranaos of the South. Having traveled from north to south of the archipelago, I can attest to the reality that what applies to the people in the North might not apply to those in the South. For instance, the women in the Tagalog region do not expose their breasts in public or have whole-body tattoos, as the Igorot women do, nor will you see women from either of these groups wearing a *sarong*, which is the everyday clothing of Maranao, Maguidanao, and Tausug women.

Another concrete example is the traditional burial practices of the Ibaloi and the Kankanai in northern Benguet, which may be unheard of in the central or southern part of the Philippines. Although, mummification is no longer practiced (mummies from the burial caves are displayed in the Kabayan Museum), the corpse is still tied to a chair in a sitting position, and, after fluids have been drained, it is treated with herbs and oil, dried in the sun, and smoked. Burial grounds and cemeteries are therefore few in the remote areas of the northern part of the country.

The Philippines is also known to have more than 100 ethnic groups, hence the second factor—variance among its people. This factor is further evidenced by the fact

that there are between 100 and 150 dialects, eight of which can be considered languages[2] (Llamzon, 1978, p.18). In addition to Pilipino, which is recognized as the national language, Spanish and English are used as official languages, which provides evidence of the third factor—the racial and cultural influences. Spanish influence is evident in the practice of Roman Catholicism, family patterns, and cuisine. American influence can be seen in the educational system, the democratic form of government, and the health services, but the identity and the core of the moral-social conscience of Filipinos is a result of a harmonious blending of Indonesian, Malaysian, and Chinese cultures. Values such as kinship, social relationships, marriage, shared residences, common interests, and community organizations are deeply rooted among Filipinos (Billones & Wilson, 1990; Lardizabal & Leogardo, 1976). The Philippine culture, therefore, is one with a multiplicity of ethnic groups, each with a distinctive culture, language, and lifestyle. This is perhaps analogous to the many layers of an onion, which have converged into a unique whole.

Inaccurate Identification in Population Studies

Before 1961, the Philippines was not even listed among the countries of origin in the reports by Statistics Canada. Immigrants from the Philippines were often inaccurately identified and indiscriminately categorized as being from "Other Countries" (Aranas, 1983). At that time, little was known about the Filipinos and their culture. Even today, Filipinos are often mistaken for Chinese, Japanese, Korean, or other Asian immigrants, and for Vietnamese and Laotians, who arrived in Canada as

[2] The languages are Tagalog (29.6%), Cebuano (24.2%), Ilocano (10.3%), Ilonggo (9.2%), Bicolano (3.5%), Waray (4%), Kapampangan (2.8%), and Pagasinenses (< 1%) (Llamzon, 1978; Enriquez, 1994).

refugees. It was not until 1966 that Filipino immigrants were recognized by Statistics Canada and by Citizenship and Immigration Canada as a separate cultural entity—as being different from other Asian immigrants (Aranas, 1983). Since then, efforts have been made to provide accurate reporting of the numbers and characteristics of the different countries. In *Profile Philippines* (Statistics Canada & Citizenship and Immigration Canada, 1996), part of a research series, the settlement patterns, family status, fertility levels, education, labor force characteristics, incomes, and other aspects of Filipino immigrants living in Canada were featured, but these statistics do not bring us closer to identifying who is a Filipino.

Inaccurate Identification in Transcultural Literature

I observed the issue of inaccurate identification and indiscriminate categorization in the transcultural nursing literature. In *Cross-Cultural Examples of Cultural Phenomena Impacting on Nursing Care* (Davidhizar & Giger, 1998), the Philippines is categorized with other Asian countries, including "China, Hawaii, Korea, Japan, and Southeast Asia (Laos, Cambodia, [and] Vietnam)," and its citizens are characterized as (a) having "dialects [and] written characters" for communication, (b) being "non-contact people" with respect to their need for personal space, and (c) being "present-oriented" (p. 15.) However, these characteristics do not apply to the people whose country of origin is the Philippines and who are referred to as Filipinos. It is true that Filipinos have dialects (approximately 100 to 150 of them), but none of these dialects has written characters, and, in fact, the people are very warm and hospitable, and as much past- as present-oriented.

I found the same table in *Fundamentals of Nursing: Concepts, Process, and Practice* (Spector, 1993), *Transcultural Nursing: Assessment and Intervention* (Giger & Davidhizar, 1995; 1999), and the *Canadian Transcultural Nursing* (Davidhizar & Giger, 1998). I also noted that a chapter was devoted to Filipino-Americans in Part 2 of *Transcultural Nursing: Assessment and Intervention* (Giger & Davidhizar, 1991; 1995; 1999), but no chapter has been written about Filipino-Canadians in the *Canadian Transcultural Nursing* (Davidhizar & Giger, 1998).

The Filipino Identity

Who, then, is a Filipino? Attempts have been made to address this issue based on birth and blood, geographical origin and citizenship, historical background, or sociocultural characteristics, but these criteria are not sufficient for describing the Filipino identity. Although all of these factors are vital for understanding the Filipino, Enriquez (1977) found them inadequate from the psychological point of view and stated that attention must be focused on Filipino identity, image (be it self-image, or projected or stereotyped image), and consciousness. He pointed out that Filipino identity is not static. An individual's self-image as a Filipino might be as varied as his/her background, and, therefore, not all Filipinos are alike. Of course this can be said of any culture. However, regardless of such diversity, the consciousness of being a Filipino psychologically defines him/her as a Filipino, no matter how he/she sees and defines the Filipino. Filipinos realize who they are the moment they encounter people from other cultures or are exposed to television, movies, computers, and other outside influences or when they themselves go overseas. As Enriquez (1994) noted, their personal experiences and awareness of being a Filipino transcend mere empathy

and concern. Enriquez also observed that although some Filipinos might not "behave" like Filipinos according to stereotypes or expectations or "look" Filipino, the main psychological element prevails—a Filipino identifies and thinks as a Filipino, and he or she acts accordingly. As Munoz (1971) puts it so well, "[A] Filipino is anyone who feels and thinks he is—who says he is a Filipino." Enriquez (1994) further explained that the consciousness of being a Filipino does not necessarily imply a valid awareness of the Filipino situation, predicament, and social reality, but it does imply an intimate knowledge of his/her personal experience as an individual Filipino. Personal experiences at home and abroad were viewed as the colonizer or the colonized, the First or the Third World, the Western or the non-Western, the dominant or the minority culture. He stressed, however, that these experiences do not exclude a growth in consciousness as the individual tries to go beyond his or her subnational, regional identity toward a national identity.

This consciousness of being a Filipino, therefore, implies identification with the Filipino as a people—being "one of them." Enriquez (1994) concluded that whatever the enculturation process may have been, whether "benevolent assimilation," "westernization," or modernization," throughout their history, Filipinos have an identity and a culture of their own that is ever dynamic, growing, and evolving.

Culturally Competent Nursing Care

Ott (1997) suggested that nursing literature abounds with articles that use the term *cultural competence* to mean (a) having an awareness, understanding, and appreciation of other cultures in addition to one's own; (b) demonstrating cultural

sensitivity and respect for the differences in groups or subgroups; and, therefore, (c) expecting outcomes that are culturally specific, appropriate, responsive, and relevant to ensure the quality of nursing care (Bernal, 1998; Fletcher, 1997; Pruitt, Gillespie, & Brown, 1999). Besides culture, definitions of cultural competence broadly include other factors such as race, gender, sexual orientation, social class, and economic situation (Meleis, Isenberg, Koerner, Lacey, & Stern, 1995). Cultural competence addresses cultural issues related to attitudes, habits, behaviors, beliefs, communication skills, ideas, interventions, knowledge, language, practices, roles, values, and ways of living. Dreher and MacNaughton (2002), however, contend that "cultural competence is really nursing competence" (p.181).

Anderson (1983) asserted that although Filipinos abroad tend to view themselves as a single people, there are significant differences in the factors mentioned above that can divide and fragment them. A concrete example of this difference is seen between Christians, Muslims, and Indigenous Peoples. Another difference is seen in the ethnolinguistic groups of Christian Filipinos, who continue to influence stereotyped social distinctions. Hence, Anderson suggested that nurses include in their nursing assessment (a) where their Filipino patients come from or, in the case of patients belonging to the second or third generation, where their parents (grandparents) came from; (b) when they immigrated; (c) their educational attainment; (d) their occupations; (e) religion; and (f) income.

One of the main concerns in nursing is human behavior, whether that behavior is identified with the patient and/or the nurse (both separately or in interaction), other health professionals, families, members of the community, or anyone else involved in

the task of providing nursing care for the patient (Brink, 1976). Leininger (1977) and McGee (1992) argued that many manifestations of human behavior are determined by culture and suggested that nurses need to be sensitive to and knowledgeable about the cultural context of the individual patient and how cultural issues affect their nursing care in order to provide individualized and effective care. Based on Giger and Davidhizar's (1990) model, Wright, Cohen, and Caroselli (1997) used the following behavioral manifestations of culture in looking into ethical decision making: family structure; communication style; concept of space; view of time; and view of health, illness, and death. They also included the culture's predominant view of autonomy and decision making. All of these behaviors can vary within and across cultural groups but provide characteristic behavioral manifestations as they apply to Filipino culture.

Culturally Specific Nursing Care

Using the Culture Care Theory and the ethnonursing research method, Leininger (1995) identified three predictive or prescriptive modes of which nurses need to be cognitively aware in giving culturally specific nursing care to Filipino patients. These modes provided the means to preserve or maintain, accommodate or negotiate, and repattern or restructure dominant care constructs. She described these four predominant cultural care constructs from ideas embedded in the worldview, social structure, environmental context, and language.

Leininger's cultural care values are similar to the dominant Filipino cultural concepts previously identified by Orque et al. (1983) in their discussion of nursing care of Filipino-American patients; the ideas of Vance (1995), who discussed ways of

applying assessment and intervention techniques to Filipino-Americans; and the writings of Miranda, McBride, and Spangler (1998) on transcultural health care for Filipino-Americans. All of these authors except Leininger referred to the three waves of Filipino immigrants to the United States. They suggested that nurses and other health professionals recognize the social and cultural distinctions between the earlier and more recent Filipino immigrants. Vance cited two implications of nursing care that were associated with the fact that the first- and second-wave immigrants had more matriarchal family structures and, overall, less education than the third-wave immigrants had. She pointed out that nurses should not only involve families but also recognize the need to modify educational approaches to the family's and the client's levels of understanding. She claimed that the diverse social and cultural backgrounds and experiences of these groups influence the beliefs, values, and attitudes toward health and health care services, resulting in the need for unique and varying approaches to health care provision.

Filipino Care Values

Orque et al. (1983), Leininger (1995), and Vance (1995) elucidated the Filipino's way of *pakikisama* ("getting along"), *utang na loob* (debt of prime obligation), *amor propio* ("saving face" or "self-esteem"), and *hiya* ("losing face" or "shame") to explain the possible culturally specific nursing care needs and how best to respond to them. To these four cultural concepts or care constructs Orque added hospitality, avoidance of direct expressions of personal feelings and disagreement, and the use of go-betweens. Leininger's (1984) findings, however, underscored the Filipinos' obligation to care by providing physical comfort, often demonstrated by

acts of tenderness, which was also evident in Spangler's (1991) study. Physical comfort and tenderness as care manifested a combined skill of showing a compassionate and kind attitude and giving soft, gentle touches in a sustained manner (Leininger, 1984). This gentle and soft touching given by Philippine nurses was contrasted with that given by Anglo-American nurses, who were inclined to touch in a hard or firm manner. Gentle nursing care meant touching in a slow and deliberate way, with thoughtful consideration of the person.

Major cultural concepts, such as *hiya* ("losing face" or "shame"), *amor propio* ("saving face" or "self-esteem"), *utang na loob* ("debt of primary obligation"), and *pakikisama* ("getting along"), were used within the context of Filipinos' strong family ties and family-centered orientation, which values *bayanihan* ("mutual help"), *kapatiran* ("kin obligations"), *damayan* ("compassion"), *pakikiramdam* ("social sensitivity"), and direct care as expected norms in all their human interactions. Orque (1983) discussed how all of these cultural values are intertwined. She pointed out, for example, that Filipinos teach their children to regard the family highly by inculcating interdependence among family members. They equate their personal well-being with that of their family and subordinate their personal interests to those of the larger groups. Thus, children are encouraged to develop acceptable behaviors, such as modesty, industry, and respect toward the family, the elderly, and the authorities because these behaviors enhance the family's name and reputation and to avoid any behavior that could bring *hiya*—a Tagalog word that connotes loss of face, or shame to the family honor.

Hiya (Losing Face or Shame)

Hiya denotes a painful emotion arising from situations perceived to be dangerous to one's ego and self-esteem. According to Bulatao (1964), *hiya* embodies timidity, shyness, embarrassment, and sensitivity, and Fox (1964) explained that its depth and extension is relative to the individual's age, gender, social status, and occupation. Orque (1983), for instance, noted that Filipino patients might feel timid (*nahihiya*) in their initial contact with a White nurse; hence, the nurse must be capable of using care related to saving face, avoidance of shame, and another mechanism closely related to hiya: *amor propio*.

Amor Propio (Saving Face or Self-Esteem)

Amor propio is a Spanish term connoting an exaggerated sense of self-worth, which is manifested in one's sensitivity to personal affront. It is used to protect and preserve one's self-esteem (Orque, 1983). For example, if a Filipino elder was a professional (a teacher, lawyer, or doctor) in the Philippines, then he or she expects to be treated with the same degree of deference in Canada that he or she received in the Philippines (Billones & Wilson, 1990). If the past experience and status are not recognized by others, the elder feels slighted or humiliated and experiences a loss of self-esteem. Lynch (1964), however, noted that the stimuli that trigger *amor propio* are only those that attack the person's most highly valued attributes, so not every minor insult would offend a Filipino.

Orque (1983) and Vance (1995) maintained that two things can happen in a nurse-patient interaction. When a nurse, for instance, is insensitive in providing care to a Filipino patient (e.g., talking down to him when certain medical terms have been misunderstood), he or she would probably not confront the nurse about this incident.

These authors further stipulated that because *hiya* and *amor propio* greatly affect Filipino patients and their family, they will henceforth avoid further interaction with the particular nurse. Filipinos are said to avoid direct expression of personal feelings, conflict, and disagreement for fear of losing face (Orque,1983), and therefore they might resort to silence (Vance, 1995).

Orque (1983) explained that in lieu of direct expressions of personal feeling, Filipinos emphasize the maintenance of their dignity, or "face," in social relationships. When self-esteem is hurt, they have a tendency to preserve their personal dignity by being silent, aloof, and reserved. They might even avoid eye contact to demonstrate self-pride. Orque (1983) and Vance (1995) noted that this is especially true in group settings and public situations. They suggested that in such situations, it might be more effective if nurses used one-to-one interactions with the Filipino patient rather than the method of group discussion. They also suggested that nurses also need to be sensitive to patients' nonverbal behaviors to discern the patients' responses to the nurses' actions. Vance (1995) suggest that nurses use "small talk" that includes safe topics, such as the weather, sports, or family members to initiate an interaction with Filipino patients who are extremely shy. Leininger (1984) stressed that wherever *amor propio* is highly at stake, the nurse needs to maintain or preserve respect for and deference to Filipino patients in giving culturally specific care.

Vance (1995) pointed out that Filipino patients experienced difficulties and embarrassment in discussing personal and sensitive topics, such as sex, tuberculosis, and their socioeconomic background, especially in a group setting, which

demonstrates the need for modesty, privacy, and confidentiality. Filipinos might resort to euphemisms, using terms such as *kuwan* ("thing") or *ang aking pag-aari* ("my private parts") to refer to the genitalia (Orque, 1983). Vance also suggested that nurses must respect the female Filipino patient's concern for modesty by giving her the choice of using any available female physician and female nurse practitioners. Male Filipino patients, likewise, should be given the option of having male health professionals attend to their needs. The nurse, therefore, will have to discuss with the patient and the family how to reestablish and repattern self-esteem to prevent exposure to shaming incidents in the hospital (Leininger, 1995).

Utang Na Loob (Debt of Prime Obligation)

Orque (1983) noted that Filipino patients can also incur *hiya* when they fail to repay a "debt of prime obligation," or *utang na loob*. She described it as a Filipino system of reciprocal obligations and behavioral expectations. She cited that whenever a nurse performs important nursing care for a Filipino patient, this may be perceived as a special favor rendered, hence an *utang na loob* relationship is created. Hollnsteiner (1964) explained that these are based on unsolicited gifts of services rather than goods. Caringer (1977) pointed out that because of his or her fear of incurring the nurse's *utang na loob*, an elderly Filipino might initially hesitate to accept that person's services despite reassurances that they are included in hospital care. Orque (1983) explained that elderly Filipinos might give a gift to the nurse because they feel obligated to repayment them for the services. According to Orque, a white nurse might not understand the patient's feeling because she considers her services to be part of her job. Another instance she cited in which patients can incur *hiya* occurs when the nurse refuses to accept food or any other nonpersonal gifts.

Based on Leininger's (1995) culture care construct, this is where accommodation and negotiation between the patient and the nurse might be clarified. In using *utang na loob* as a care construct, Leininger described it as "giving in anticipation and without an immediate return." Filipino nurses who perform acts of reciprocity as caring would not expect to return acts of kindness immediately, but rather would wait until a need arose. Leininger explained that reciprocal care giving should always fit the time, occasion, and event. *Utang na loob* operates within a Filipino family in a much deeper context than mere gift giving. It means giving help to others in time of need or when the need for assistance is evident. These caring acts are given graciously, sincerely, and freely, without hesitation and reservation on the part of the giver.

Pakikisama (To Go Along With)

Another related value is *pakikisama*. This term is derived from the root *sama*—meaning "to accompany" or "to go along with." Orque (1983, p.156) explained that that an individual who is said to value *pakikisama* "assent to the suggestion of another." She found this consistent with the "value of adopting the larger group's interest over one's own." A Filipino who upholds this value "would rather yield to the will of the leader or the group to make a decision unanimous" (Orque, 1983, p.156) or "concede gracefully without conflict or disharmonious relationship (Leininger (1995, p. 352). Vance (1995) described this form of agreement as the tendency of Filipinos to behave agreeably even to the extent of personal inconvenience. This is the ability to get along with others at all cost. When someone in authority confronts an elder, the elder may "give in to," or conform to the will of, that person even if it is contrary to the elder's own feelings or ideals (Billones & Wilson, 1990). In Leininger's culture care construct, *pakikisama* functions to

maintain smooth and harmonious interpersonal relationships and to avoid any conflict, confrontation, or disruption to save face.

Filipino Culture Care Constructs

Leininger (1995) outlined some general principles for providing culturally congruent care to Filipino clients with traditional cultural values:

1. Show deference, respect, and kindness to clients, especially the elderly. Consider that the elderly prefer to be cared for in their home by extended family members rather than in a nursing home.
2. Involve and facilitate extended family members in nursing care activities, whether at home or in the hospital, as an essential factor in the client's wellness or ability to face death.
3. Consider ways to maintain nonaggressive relationships with Philippine clients, and avoid confrontations and the loss of self-esteem.
4. Respect clients who value privacy and quiet times as essential to their recovery or well-being.
5. Accept gifts that reflect mutual reciprocity without feeling compelled to return a gift immediately.
6. Ask clients how they would like to be cared for and what comfort measures they would like to receive.
7. Consider that pain may be viewed as a gift from God, and often the client can endure more pain than most Anglo- or Jewish-Americans can. However, small doses of medications to relieve postoperative or chronic suffering might be essential to clients. (p. 358)

Other Cultural Values

The transcultural nursing literature abounds in concepts such as *hiya, amor propio, utang na loob, pakikisama,* and many others that have been used in culture care constructs as previously discussed. Miranda et al. (1998) discussed the need to use other cultural concepts and interaction models in qualitative clinical studies to clarify and understand Filipino social interaction within the context of nurse and patient interactions.

Pakikiramdam (Social Sensitivity)

To save face (*amor propio*) and to avoid losing face (*hiya*), Filipinos pay close attention to the feelings of others. Hare (1969) noted that this social sensitivity (*pakikiramdam*) enables Filipinos to readily sense subtle cues and to deliberately consider others' evaluation of them. They might agree even when they mistrust the physicians or nurses, because they do not want to risk hurting the other person's feelings. Initially, an elderly Filipino patient might not tell the nurse any criticism of her nursing care for fear that it might displease her. The nurse, therefore, must be sensitive to the nonverbal cues of the patient's response to the care given.

Miranda et al. (1998) referred to this social sensitivity in a slightly different context. They spoke of Filipinos' having "intuitive feelings" about other people and the contextual environment during their interaction. They also alluded to family members' having "intuitive knowledge" of each other to an extent that understanding is developed even without the use of verbal communication. They observed that Filipinos, who are used to this "highly contextualized" communication, are often perplexed or even offended when asked to be exact and precise in their

communication. Most Filipinos prefer not to communicate directly to avoid stressful interpersonal conflicts and confrontation (Eggan, 1971).

Tagapamagitan (Use of Go-Betweens)

The use of go-betweens is another way of avoiding embarrassing face-to-face encounters or lessening the effects of existing conflicts. These intermediaries can be effective at preserving or restoring smooth interpersonal relationships between disagreeing parties. Older members of the family or highly respected community members are usually chosen to play this role.

Pakikipagkapwa-tao (Shared Human Identity)

Miranda et al. (1998) alluded, for example, to the cultural concept of *pakikipagkapwa* (shared human identity), which takes its roots from the core value *kapwa*—inadequately translated as "others." In English, *others* implies the acknowledgement of one's self as a separate identity. It is often used in opposition to oneself, whereas in Philippine language, *kapwa* is the recognition or acknowledgement of a shared identity. It is the unity of the self and the others. When used, therefore, with the prefix *pakikipag*, as in *pakikipagkapwa tao*, it means to have someone share one's identity as a human being. The concept of *pakikipagkapwa* has been explored in other social interactions, such as food sharing among the Bulakenos, by social scientists from the psychosocial perspective (Santiago, 1976).

Modes of Interpersonal Relations

Santiago and Enriquez (1976) identified eight levels of social interactions for the concept of *pakikipagkapwa*:

1. *Pakikitungo* (transaction/civility with)
2. *Pakikisalimuha* (interaction with)
3. *Pakikilahok* (joining/participating with)
4. *Pakikibagay* (in conformity with/in accord with)
5. *Pakikisama* (going along with)
6. *Pakikipagpalagayan/pakikipagpalagayang-loob* (being in rapport/understanding/acceptance of)
7. *Pakikisangkot* (getting involved)
8. *Pakikiisa* (being one with)

The distinctions among these eight modes of interaction are said to have implications beyond the conceptual and theoretical. They are not just interrelated modes of interpersonal relations; they also represent interactions that range from relatively uninvolved civility, or *pakikitungo*, to the total sense of identification, or *pakikiisa*. Miranda et al. (1998) further noted that these levels of interpersonal relations are not only conceptually but also behaviorally different.

Social Interaction Model in Food Sharing

Santiago (1976), among others, has examined the language of food—which is really the language of interpersonal relationship in food sharing—among the Filipino

Bulacan middle class. She looked at five behaviorally recognizable levels under two general categories:

Ibang tao, or "Outsider" Category

Levels:

Pakikitungo (amenities)

Pakikibagay (conforming)

Pakikisama (adjusting)

Hindi ibang tao, or "One of us" Category

Levels:

Pakikipagpalagayng-loob (mutual trust)

Pakikiisa (fusion, oneness, and full trust)

These levels of interpersonal relations have not been explored to date in the transcultural nursing literature. Enriquez (1994) inferred that Lynch (1964), in his construct of smooth interpersonal relationship, might have successfully penetrated the highest level of social interaction for *ibang tao*—the outsider's domain. However, he pointed out that although *pakikisama* (to go along with) is valid, it explained only a portion of Filipino social interaction values, which are brought about according to socially defined rules of behavior. He proposed that *kapwa* embraces the two categories of *sariling tao* (insider) and *ibang tao* (outsider) and depicts a person's ties with fellow human beings. In fact, the Philippine language provides two pronouns for the English *we*, which indicates clearly how significant the core value *kapwa* is to Filipinos: *tayo* (an inclusive *we*) and *kami* (an exclusive *we*). Miranda et al. (1998) noted that although concern for others and maintaining good relationships might still

be foremost to Filipinos residing in the United States, the insider and outsider delineations might be less important, especially among recent immigrants. They claimed that Filipino-Americans, who are highly educated, take pride in their outlook and perceive themselves as "global people." Awanohara (1991) stated that recent Filipino immigrants find it easy to ally themselves with people from various cultures and hence are able to acculturate better than other immigrants, who settle in ethnic enclaves.

Summary

Culture is learned, shared, and passed on from one generation to another. It is a characteristic way of life within which individuals acquire qualities that distinguish a member of one culture from that of another. It constitutes a particular group's values, beliefs, customs, traditions, norms, and life ways that guide their thinking, decisions, and actions in patterned ways that provide their context—human definitions of life situations. Such common patterns within a given culture define the boundaries of different groups, yet even within a specific cultural group, variations exist based on the degree of acculturation into the mainstream.

These variations are particularly true of the Philippine culture, described as one with a multiplicity of ethnic groups, each having a distinctive culture, language, and lifestyle. However, despite their heterogeneity, Filipinos have an identity and a culture of their own that is ever dynamic and evolving. Enriquez (1977) pointed out that the personal experiences and awareness of being a Filipino implies identification with the Filipinos as a people—being one of them. Such consciousness transcends mere empathy and concern. He also explained that the Filipinos' realization of their

Filipino identity becomes evident the moment they come in contact with people from other cultures. Their family-centered social structure determines who are *sariling tao*[3] (insider) and *ibang tao* (outsider). Yet, their *kapwa*-oriented worldview enables them to identify other people as being one of them.

Despite an extensive search, this literature review revealed only a limited number of studies concerning Filipino-Canadians. I also discovered that although studies concerning Filipinos living in United States are more common than those relating to Filipinos in Canada, few studies have been done concerning their health and illness beliefs and practices, and their health needs and conditions. The literature review indicates that much attention has been given to Filipino values such as *hiya, amor propio, utang na loob*, and *pakikisama* in formulating culture-specific nursing care. However, there is an obvious need to explore other cultural values, such as *pakikiramdam* (social sensitivity), *tagapamagitan* (the use of go-betweens), *pakikipagkapwa* (shared human identity), and modes of interpersonal relations in the nurse-patient interaction. There is also a need for researchers, especially in the fields of health sciences and nursing, to consider not only the nurses' but also the patients' experiences and perceptions.

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[3] *Sariling tao* is a term in the Philippines for family members, but there are not too many family members and relatives in Canada; *hindi ibang tao* is a term used to extend the family circle.

CHAPTER 3

METHOD

The method of choice in a research study should be driven by the research question, how much is already known about the topic, the maturity of the concept, and constraints concerning the subjects or setting (Morse & Field, 1995). Based on the research question—What were the Filipino-Canadian patients' experiences of being cared for by nurses from other cultures? —and because relatively little is known and has been written about these experience, that is, the concept of cross-cultural nursing care for Filipino-Canadians, the method of choice was a qualitative one, specifically, focused ethnography.

Ethnography

For purposes of this study, I used ethnography as "a generalized approach to developing concepts to understanding human behavior from an emic point of view" (Field & Morse, 1985 p. 21). By emic point of view, I meant to take the Filipino-Canadian patients' perspectives rather than the multicultural nurses' perspective, because studies done earlier in transcultural nursing were mostly from the latter point of view. The Philippine culture is heterogeneous, and an emic perspective forces the recognition and acceptance of diversity among Filipinos. Documenting this diversity was crucial in understanding how the Filipinos think and act. Awareness of differing perceptions was useful in assessing the status quo. It was also useful in detecting distinct differences in the behavioral responses and patterns of interactions drawn inductively from experiences of Filipino-Canadian patients within the multicultural context in which they live. Researchers are seldom without theoretical orientation and

I tried to put on hold any conceptual or theoretical framework unless they were found relevant to any themes that emerged from the data. As an insider, I do have my own assumptions and knowledge of the Filipino culture but to my surprise there were things that I was not aware of until I was asked why we think, talk and act the way we do.

Ethnography is always informed by a concept of culture that enables the ethnographer to go beyond what people say and do to understand the shared system of meaning referred to as *culture*. It is, therefore, based on the assumption that culture is learned and shared among members of a group and thus can be described and understood (Morse, 1994). This ethnographic method was guided by a presupposition that over time, Filipino-Canadian patients' interpretations of experiences came to constitute a perspective representing a combination of beliefs, attitudes, and behaviors that characterized the way they view the world. It was also based on the presupposition that some cultures shared a specific social, psychological, and cultural problem that had not necessarily been articulated. This presupposition was true to most Filipino-Canadian patients, who found themselves in a cultural environment that was for most of them strange and different from what they had been accustomed to in the Philippines.

Focused Ethnography

I conducted this study using a specific type of ethnography: focused ethnography. I chose this method because little is known concerning Filipino-Canadians living in one of the largest cities in the western side of Canada and their experiences of being cared for in a hospital setting. Nurses in this study referred to

those who provide nursing care on a day-to-day basis regardless of whether they are registered or licensed practical nurses. Morse (1987) and Muecke (1994) have described focused ethnography as being delineated yet context bound: delineated because I was interested in a particular experience—of being cared for by nurses from other cultures—and context bound because the scope and delimitation were well defined—only Filipino-Canadians living in one of the largest cities in Western Canada. I studied, therefore, the specific experience of *being cared for by nurses from other cultures* not only within the institutional level, which is the hospital setting, but also within the broader context of the societal level—*living in Canada.*

The characteristics of this study fit well the description of focused ethnography outlined by Morse and Field (1995):

- The topic—being cared for by nurses from other cultures—was selected even before data collection began rather than emerging during the data collection.
- Participants were linked by a common experience of being hospitalized.
- Participants were connected by the same culture in its broadest sense, and they shared behavioral norms and a common language emanating from the experience of being cared for by nurses.
- Experiences were limited to the time when patients were hospitalized. (pp. 154-155)

The use of focused ethnography exploring the experiences of Filipino-Canadian patients of being cared for by nurses from other cultures allowed me to

examine areas of patients' care in a particular context that had not been viewed by other researchers.

Filipino-Canadians

Canada's population is comprised largely of immigrants who have come from all parts of the world.[4] A significant change, however, has been observed in the numbers and origin of immigrants to Canada. Historically, the European-born represented the largest proportion of all immigrants living in Canada. However, for the first time, in the latter part of the 20th century, this group of immigrants has declined remarkably to less than half of the total immigrant population, from 67% in 1981 to 47% in 1996. In contrast, immigration to Canada from Asia and the Middle East has increased from 14% in 1981 to 31% in 1996 (Statistics Canada, 1997).

Filipinos make up one of the largest groups of immigrants arriving in Canada from any one country (Statistics Canada & Citizenship and Immigration Canada, 1996). According to the 1991 Census, there were at that time 123,300 immigrants born in the Philippines who were living in Canada.[5] At the time of the 1996 Census, this figure had increased to 184,550. In contrast, Philippine-born immigrants represented less than 1% of all immigrants arriving in Canada each year in the mid-1960s (Statistics Canada and Citizenship & Immigration Canada, 1996). This number

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[4] In 1996, the total number of immigrants in Canada was 4,971,070. This includes total immigrants (all permanent residents born outside Canada) and recent arrivals (new immigrants who arrived in Canada in the last recorded year, in this case, those who immigrated between 1991 and the first four months of 1996). Since 1991, there has been a 14.5% increase in the total number of immigrants, slightly more than three times the growth rate (4%) of the Canadian-born population (Statistics Canada, 1997).

[5] The largest proportion of Canadian immigrants from the Philippines reside in Ontario. In 1991, 50% lived in Ontario, while 20% lived in British Columbia, 31% in Manitoba, 10% in Alberta, 6% in Quebec, and 2% in the remaining provinces combined. More immigrants from the Philippines live in Toronto than in any other city. Immigrants from the Philippines however, make up a larger share of the total population in Winnipeg than in any other urban area (Statistics Canada, 1997).

represents 3.7% of all immigrants, ranking the Philippines eighth among the places of birth for total immigrants, including those who arrived before 1961 and recent immigrants (new immigrants who arrived in Canada between 1991 and the first four months of 1996) (Statistics Canada, 1997).

Similar trends have been observed in other provinces. Since 1991, the number of immigrants in a couple of cities has grown at the same rate (6%) as the Canadian-born population. The Philippines ranks first as the place of birth for total immigrants and for recent immigrants in several major cities in Canada. Three cities in Western Canada had the highest proportion of Filipino immigrants, hence the timely and relevant choice of this study's setting.

Sample

In this study, I used purposive sampling to identify participants. I selected participants based on their experience of having been cared for by nurses from other cultures and on the need to collect data to examine and develop categories as they emerged from the concurrent analysis of the data.

The first step in this study, before even gaining access to research participants, was to attend to culture-specific protocol. First, I paid a courtesy visit to the Philippine Consul General, who invited me to meet the Philippine ambassador to Canada during one of his visits. The Consul General also introduced me and endorsed my research project to the presidents of the various civic, professional, and religious organizations. In addition, I contacted the pastors and leaders of the faith communities and parishes, who introduced me to their lay leaders, who in turn had direct contact with Filipino-Canadian members. I then requested opportunities to

speak formally and informally with Filipino-Canadians in their meetings or social gatherings and asked to be introduced directly to anyone they knew who fit my selection criteria. The purpose of this initial step was to make Filipino-Canadians living in one of the cities located in western Canada aware of my research and to find prospective participants.

The acquaintances I made through these organizational meetings and social gatherings expanded my network of referrals. Another strategy I used to gain access to my participants was asking for free page space and airtime to advertise my research study in local Filipino newspapers and radio programs. Other than those who responded to the advertisement, most of my participants were accessed through a referral, or snowballing, technique. In the snowball technique, several participants introduced me to other family members, relatives, or friends who had had the experience of being hospitalized. To avoid bias, I did not restrict my system of referral or networking to my participants but also requested referrals from church communities, religious, professional, and civic organizations.

Sample Selection

The participants in this study met the following inclusion criteria:

- first-generation Filipino male and female adult immigrants, born in the Philippines;
- lived in western Canada and had the experience of being in hospital in the past 5 to 15 years to ensure that they are able to recall the experience;
- 18 years of age and older; and
- had been hospitalized in a Canadian hospital for more than 3 days.

In addition to the above-mentioned selection criteria, I selected individuals based on their ability and willingness to give an account of their experiences.

Although participants had the option of using either English or Pilipino, many actually shifted from Pilipino to English or from English to Pilipino in articulating their experiences of being cared for by nurses from other cultures, especially when they could not find equivalent words in either language to describe what they wanted to say. Other participants used Tag-lish—a combination of Tagalog[6] and English in the same sentence or the addition of Tagalog prefixes and suffixes to an English root word.

Sample Size

Twenty participants were interviewed in their homes, and three were interviewed in a coffee shop. The number of interviews depended on the accuracy and adequacy of the data. Careful identification and the actual involvement of participants who are best experienced and knowledgeable were essential determinants for the appropriateness of the data. I assessed the adequacy of the sample size according to the adequacy of the information obtained from the sample (Morse, 1986). In the beginning, Filipino-Canadian patients who were referred and responded to participate in my study were those who had the experience of being hospitalized during their childbirth. Later, I had to refuse interviewing mothers and look for those who were hospitalized for other reasons.

Saturation was reached when no new data were emerging from further interviews, the data were becoming sensibly consistent and free of gaps, and other

cases had been investigated. After meeting the criteria of appropriateness and adequacy, I was able to develop from the data a full and rich description of the phenomenon, thus ensuring the reliability and validity of the study. It was not my intent to generalize the study's findings to other situations but rather to develop a culturally specific understanding of Filipino-Canadian patients' experiences of being cared for by nurses from another culture.

Data Collection

I used an array of ethnographic techniques, including participant observation, unstructured interviews, field notes, and a personal diary in collecting my data over a period of four months. Data sources included government documents from Statistics Canada and Citizenship and Immigration Canada. The subsequent subsections include discussions of techniques and other strategies I used in the process of collecting and analyzing my data.

Observation

For the purposes of detecting distinct differences in the behavioral responses and patterns of interactions drawn inductively from the experiences of Filipino-Canadian patients within the multicultural context in which they live, I used participant observation as a data collection technique. This choice was based on my realization that had I not come to live in one of the largest cities of Canada or had I not gone to visit them in their homes, I would not have understood and given an accurate account of their experiences. I had this privilege of being invited as "one of

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[6] Tagalog is one of the eight major dialects but is considered a language. Although Pilipino is the national language, Tagalog is popularly known as the primary language of the country (Karnow, 1989).

us" (*hindi ibang tao*) in their homes. I knew the moment I stepped in their doorway that I was treated as "one of us" (*hindi ibang tao*), and even in the very few situations where I was not quite sure, I found out soon enough during the meal or snack. This might be strange for non-Filipinos, but however one interprets it, participants in the food-sharing situations in the Filipino context know more or less whether they are being treated as "one of us" (*hindi ibang tao*) or "not one of us" (*ibang tao*). This was easy to detect in terms of where the meal was served, what was said, the props used, the kind of dishes, and the total eating context (Santiago, 1976). I also had the opportunity to celebrate several traditional festivities, such as the *Simbang Gabi* at Christmas, with a large Filipino community in the city and be abreast of what was happening to them in the city as a whole. The purpose of these observations was to obtain an accurate, detailed description of the setting in which the participants lived (their homes in particular and the different districts in the city) and what was happening there. These observations provided added breadth to the study and any context that interviews failed to provide. In fact, visiting participants in their homes enhanced my interviews a great deal. I must confess that the social interactions I had with my research participants and their families were helpful in guiding subsequent observations and interviews. At the end, these observations served as validation to the "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) findings I drew from the interviews.

With regard to the experiences of the research participants when they were in hospital, there were several reasons for taking the retrospective account of their experiences through interviews instead of doing participant observation in the actual

nursing care. First, it would be a real challenge to participate in providing the actual nursing care and at the same time observe what was going on and still remain objective. Second, it might be difficult to obtain the consent of both the nurses and the patients, and even if I did receive their consent, their awareness of my presence might make them self-conscious and possibly even nervous, thus affecting the data inadvertently. Third, patients, for example, who might be in pain, might not want to have people around all the time. I think this is true of most Filipino-Canadian patients. Fourth, they might not have a full grasp of what is going on within themselves and around them. Only in hindsight do they realize the significance of events that might have had a large impact on their experience as a whole. Finally, based on the ethical principle, it is always in the best interest of the patients and protecting the privacy of the patients undergoing nursing care procedures that we choose the best technique for collecting data.

Field Notes

Field notes of the observations consisted of daily written notes. These took the form of reconstructions of observations and conversations, and were used to supplement the tape-recorded interviews. These brief notes recorded in the setting were placed in a small notebook and served to capture as many details of an interaction as possible. I transferred these notes to a personal computer system on the same day as the interview to prevent loss of information and to ensure accurate recall of the visits.

Unstructured Interviews

I personally conducted one or two unstructured interviews with each participant to collect data. The first interviews were all face-to-face; a few follow-up interviews and the more structured interviews were conducted by telephone. The purpose in doing face-to-face interviews was to give me an opportunity to ask the research participants superficial and broad questions, increasing the depth and specificity as categories and/or relationships were identified. I also used a demographic data collection sheet that included important information, such as (a) code number, (b) name, (c) age, (d) gender, (e) marital status, (f) religion, (g) language and dialects spoken, (h) educational attainment, (i) occupation, (j) income, (k) when the patient migrated to Canada, and (l) where in the Philippines the patient or his or her parents came from (see Appendix 4). These demographic data were used only for purposes of analyzing the data and to protect the participants' anonymity, I have not reported individuals' details here.

The first part of each interview was spent soliciting participants' consent to participate in the study, and the second part was composed of the unstructured interview. All interviews were conducted in English and Pilipino, the national language of the Philippines. Because I can speak and read the national language and three other major dialects, no interpreter was necessary. For the face-to-face unstructured interviews, consent was in written form, whereas the consent for the telephone interviews was tape-recorded separately from the interviews. Audiotaped interviews were transcribed immediately for the concurrent analysis. I was constantly aware of the ongoing nature of the consent given by the participants from the

beginning until the end of the study. The participants were free to revoke their consent at any stage of the study or to withdraw certain information about themselves or their experiences as the interview progressed.

Throughout the study, I took on a learner's role, as the participants had the information that I was seeking. Tape-recorded interviews were conducted with each participant, and the interviews lasted between 30 and 90 minutes. The amount of time depended largely on the amount of information the individual was willing to share and his or her contribution to emerging themes and patterns. To establish the trust and cooperation of the participants, I conducted the interviews in a quiet place, a room that was free from interruptions while participants told of their experiences. If the interviews took place in the living room, I made sure that the participants were at ease with any individual who was within hearing distance. If the participants showed signs of uneasiness or hesitation, I politely requested whoever was there to excuse us, and they willingly went somewhere else in the house.

Following completion of informed consent procedures, I started the interviews by obtaining the demographic information. However, if the situation warranted it, demographic information was collected at the end of the interviews.

I began the face-to-face unstructured interviews with a broadly based question that invited the participants to tell me their experiences of being sick and in hospital:

> Tell me about your hospital experience(s). Please start from the time you first noticed you were ill.

Following this, I used probes to target specific area(s) of information; these depended on the participants' responses. Possible probes included

- Tell me who took care of you.
- Tell me how you communicated.
- Tell me about how you asked for something.

Questioning strategies that were employed to help participant articulate their experience(s) included asking about a specific incident and/or about a similar experience(s). Probes included

If you were to be admitted again (specify incident no. 1),

- what would you say?
- what would you do?
- how would you prefer the nursing care to be done?

If you were to undergo a similar experience (specify incident no. 2),

- what would you say?
- what would you do?
- how would you prefer the nursing care to be done?

Then, I asked the participants if there was a nurse or an incident that stood out in their memory as they recalled their hospital experiences:

If you had a chance to talk with this nurse who took care of you,

- what would you tell her/him?
- what would you recommend she/he do in the future?

Near the end of the interview, I asked the participants to sum up their experience(s) using the following probes:

If another Filipino-Canadian approached you and asked what to expect from nurses who came from another culture,

- what would you say to her/him?
- what would you recommend she/he do?

If another Filipino-Canadian approached you and asked what not to expect from nurses who came from another culture,

- what would you say to her/him?
- what would you recommend she/he do?

I transcribed all the audiotaped interviews verbatim immediately. I also translated all transcripts into English and checked for accuracy by reviewing the tapes and transcripts with a colleague. The analysis of the initial interviews, in addition to the data gathered using the previously discussed data collection techniques, determined initial categories and directions for subsequent interviews. Based on the data gathered from these interviews, I decided to either go ahead or make necessary changes in the selection criteria—the type of participant who best served the purpose or who in the list of referrals would be interviewed next. Eleven follow-up interviews clarified and filled some gaps in the subsequent analysis. These interviews yielded both positive and negative experiences, which led me to information that I had not anticipated before collecting and analyzing the data. The subsequent or follow-up interviews were more structured and involved questions that were more direct to validate and extend the understanding of the structure of the data. The follow-up interviews made the data richer and thicker. The technique of concurrently collecting and analyzing the data verified and validated data gathered from previous interviews. It also gave me the opportunity to fill in gaps and to double-check information with the same participants or to crosscheck with other participants.

Personal Diary

I kept a personal diary to record my impressions and hunches. This diary was useful for keeping track of my personal thoughts and feelings during the study. I recorded insights and other thoughts on a regular basis, and these served as reminders.

Data Analysis

I collected and analyzed data concurrently. This particular approach ensured what Robertson and Boyle (1984) and Spradley (1980) called sequential data collection, used to characterize a situation and to offer an in-depth descriptive analysis within the cultural context. To achieve this goal, I adopted several strategies, such as observation, unstructured interviews, field notes, and a personal diary. I transcribed the audiotaped interviews verbatim and checked them for accuracy by reviewing the tapes and transcripts. I also translated those interviews done in Pilipino, and reread and counter-checked the original interview transcripts with the translated text. I listened to the audiotaped interviews, reread the original and translated transcripts repeatedly to double-check meanings and contexts when necessary, and counter-checked with field notes for significant incidents, patterns of behaviors, isolated situations, and recurrent themes or statements made by the participants.

Coding, Sorting, and Filing System

Initially, I applied a manual method of using highlighting pens to establish a system of sorting and filing data. I coded the recurrent words, phrases, and themes in the right margin of the transcripts and field notes and grouped them according to broad categories. The spaced paragraphs and wide margins on each page provided room for notations and coding processes. Each transcript and field note was photocopied, cut, and pasted under the category where it seemed to fit. I assigned a color to each participant, and corresponding colored paper was used for printing the transcripts. These colors identified each participant and distinguished each interview. All pages of the transcripts were numbered sequentially, and I indicated participants'

numbers and interview numbers on each page. Significant passages were cut and pasted onto a full-sized sheet of paper and filed into a folder that represented each category created. I found the color-coding method the most effective technique of identifying all data and tracing coded and categorized pieces of data to the original source. As I became more familiar with my system of coding and assigning categories, I decided to store all the transcripts and analyzed data electronically using a Compaq Presario® computer notebook and Microsoft Word® software.

I coded, sorted, and filed each transcribed and translated interview by opening simultaneously multiple windows. As I read the interview files in one window, significant words, phrases and/or paragraphs were highlighted by using bold, italics, and underline functions, and I inserted comments or notes directly into the file. I also copied and sorted text into appropriate categories/files, which were either maximized or minimized on the screen. These segments of data, copied and pasted into their respective categories/files, were labeled according to the participants' code numbers, the interview numbers, and the page number on the original transcribed interview text. Page breaks were inserted between each entry for easy access and resorting when necessary. This saved a great deal of time coding, copying, sorting, filing, and searching the data. This electronic method retained the highlighted text and made it easy to insert relevant data from my field notes and personal diary as comments and footnotes. It also allowed me to cross-reference and hyperlink one piece of data to another when doing the analysis and further literature search. It was also useful for further sorting and reprinting when new categories and themes emerged from the data.

Content Analysis

I used content analysis when significant themes emerged from the data. This technique of analysis was useful in helping me to recognize behavioral responses and patterns of relating. As the coding progressed, specific categories were created, and I developed a filing system that provided a flexible way of storing and retrieving data. Field notes written during the observation, transcripts from the unstructured interviews, and relevant notes in my personal diary were systematically reviewed, summarized, and thematically analyzed and interpreted. I did an in-depth analysis of explicated themes, patterns, changes, linkages, and interrelationships that arose from the data. I also tried to identify exemplars, and I reexamined all the findings for their practicality and applicability, consistency and fit with actual experience, openness and neutrality, and independence from bias and/or the acknowledgement of one's own biases.

Comparing and Contrasting

The initial content analysis and coding from the first round of interviews and observations involved the identification of open, substantive codes that were highlighted in italicized, underlined, and bolded text. Each theme and example identified in the interviews and field notes was coded. At that point, I used as many codes as possible to ensure a thorough coverage. I constantly compared and contrasted emerging codes and categories with those identified in earlier interviews by simultaneously opening multiple windows. As data within each category were compared and contrasted, new categories emerged, some categories were merged, and

subcategories were created. Comparing and contrasting the different categories helped me to ensure that they were mutually exclusive.

Establishing Linkages and Relationships

I recognized and established linkages between and among categories throughout the process of data analysis, and these provided a conceptual order for the developing categories. As more information was compiled on each theme, the major categories were sorted into smaller ones. I compared findings from previous studies with data collected from the participants to verify and extend the analysis. I developed hunches about relationships among behaviors, participants, and experiences within the data, which developed into tentative propositions about certain relationships. These tentative propositions guided further data collection and analysis. Discussions with members of the supervisory committee, think tank groups, professional colleagues, and peers validated my findings. These discussions and reflections led to refinement of the linkages between the data. Coding, categorizing, and analyzing the data ended when all the categories had been placed into a conceptual framework.

Negative Cases

Denzin (1978) described *negative cases* as those that are atypical—to refer to those participants who appear infrequently and depict a small range of behaviors or events not commonly observed in the larger group. These negative cases served to verify and clarify significant characteristics or behaviors that I observed. Representative cases are those participants who appear with regularity and encompass the range of behaviors that are described within each category (Denzin, 1978).

I continued analyzing the data with each subsequent face-to-face and follow-up phone interview and observation until no new information was gathered and no new categories emerged, and when no other negative participant or behavior was found.

Reliability and Validity

I took the responsibility to ensure an accurate description of the account of the participants' experiences. All factors that enhanced the credibility of the research were taken into consideration. This section is divided into two subsections: (a) the sampling approach as explained by Morse (1986) and (b) the researcher's origin vis-à-vis the method. To enhance the reliability of this study, I kept detailed field notes, reflecting an objective description of the participants, setting, behaviors, and subjective impressions, ideas, and hunches. Doing so was in keeping with the recommendation to clearly delineate the physical, social, and interpersonal contexts within which the data were gathered (LeCompte & Goetz, 1982). I also kept track of all the decisions made in the process of performing this study by writing regular memos.

Validity is the extent to which the findings of this research study represented reality (Field & Morse, 1985). It includes two related components, the first of which is internal validity. This refers to the degree to which I actually observed what I believe I was observing. The other component is external validity. This refers to theoretical generalizability. The former is known as the major strength of qualitative research, because data are considered as grounded in reality by the inductive approach, whereas the latter is not the goal of this particular study (Aamodt, 1982;

Field & Morse, 1985; LeCompte & Goetz, 1982). Of course, findings of this study can be transferred to other cultural groups with similar characteristics in a comparable setting.

The array of multiple techniques that I used in collecting the data for this study served to counter-check data gathered through the various data collection techniques, such as observations, field notes, unstructured face-to-face interviews, the follow-up phone interviews, and my personal diary. The visits to the homes of the participants allowed me to observe their living and community environment as well as their family situation. The unstructured nature of the interview format gave me every possibility to explore the participants' experiences. The field notes, as mentioned earlier, were helpful in keeping track of all the observations, and I recorded in my personal diary my feelings, thoughts, insights, hunches, and impressions that might bias or influence the findings. I tried to make myself aware of all these to enhance not only the reliability but also the validity of the study. Careful use of the ethnographic techniques will ensure that developing ideas, categories, and concepts emerge from the data.

The identification of common themes, ideas, and concepts from detailed observations in the form of field notes and transcripts, rechecking observations, clarifying participants' statements, and reviewing the accuracy of the verbatim transcription with the tapes were all done to make sure that the participants' experiences are not misrepresented. I arranged meetings with supervisory committee members or with some of my colleagues to share interpreted data as a way of enhancing the reliability and validity of this study. I also compared and matched

categories to refine the constructs and to achieve the best possible description of the participants' reality.

The Sampling Approach

Appropriateness and adequacy were two important sampling criteria that I used to ensure the reliability and validity of the research findings. Purposive sampling was used to obtain appropriate participants, who were deliberately selected based on inclusion criteria. Further selections were determined by categories or linkages that emerge from the initial data collection and analysis. This approach allowed a full range of variation in categories to emerge, which is necessary to guide the emic perspective of the phenomenon under study.

I used the criterion of appropriateness to evaluate the representativeness of the data, and adequacy was used to evaluate the quality, completeness, and amount of information provided by the participants. The voluntary participation of individuals who had the experience of being cared for by nurses from other cultures increased the likelihood that the most representative and insightful data was obtained and the criteria of appropriateness were met. I considered the data gathered and analyzed in this study adequate when saturation was met—meaning that the information was repetitive and a sense of coherence was achieved (Morse & Field, 1995). It also covered as many different cases with varying illnesses as possible. I also verified data analysis with original participants whenever possible and when I deemed it necessary.

The Researcher's Origin Vis-à-vis the Method

Traditionally, ethnographic studies are conducted by researchers who are willing to go to cultures other than their own. They try to be like the people they have

chosen to study. As the researcher in this study, I did not have to make an extra effort to establish commonalities, as a non-Filipino researcher would be required to do, to gain, build, and maintain the trust and confidence of the participants. In this case, I was very much like my participants. I was born in the Philippines and lived there until I came to Canada in 1997 to obtain my doctorate at the University of Alberta. The only difference between the participants and me was the participants' immigrant status, which might very well have implications for their worldview and their experiences of living in Canada. Like most qualitative research, ethnography runs the risk of criticism for its subjectivity. Morse and Field (1995) cited two possible sources of such subjectivity: first, the subjective nature of the research topic; and second, the researcher-as-an-instrument. The subjective feelings of the research participants were an integral part of how they perceive, report, or account for their experiences, the situation, or the events surrounding the experience. This part of the context is essential in ethnography.

My extensive involvement as the sole interviewer in this study and as being responsible for data analysis enhanced the process. However, relationships that developed between the research participants and me were constantly discerned to make sure they did not affect or influence the collection and the analysis of the data. I was careful not to become too close or attached to any of the participants. I have described the relationships I developed with my research participants so that validity of the study can be more adequately judged. The quality of the data and the depth of the analysis depended on my (a) ability, (b) sensitivity, (c) perceptivity, (d) informed value judgment, (e) insight-fulness, (f) knowledge, and (g) skills in observing and

listening. The most important factor, however, was establishing rapport and gaining the trust of the participants.

Ethical Considerations

A letter informing all participants about the study (Appendix 3-A and -B) was mailed early on, before I arranged for the visits and unstructured interviews. Doing so provided every research participant with ample time to consider carefully whether he or she wished to participate in the study. On the day of the scheduled visit, I once again reviewed the letter together with the consent form (Appendix 3-A and -B) asking the research participants to sign. These signed consent forms were assigned code numbers, which were later used to identify the tapes and transcripts. Signed consent forms with the code numbers were securely locked in a drawer at my office. All recorded interviews, transcriptions, and pertinent data will be locked securely in a separate filing cabinet for at least 7 years after this study has been completed.

For the purpose of anonymity and confidentiality, transcriptions did not bear the names or other means of identification of the research participants or other persons or institutions mentioned in the interviews. Code numbers and characters rather than the actual names were used to represent research participants, persons, and institutions mentioned in all the transcriptions.

The Health Ethics Review Board of the Regional Health Authority reviewed and approved this study (Appendix 5). I did not ask anyone to participate in this study who had not given fully informed consent. Research participants were free to terminate any visit and/or interview (face-to-face or phone) at any time and were not required to talk about any subject they did not wish to discuss. Throughout the

succeeding chapters, I use pseudonyms to protect the identities of my research participants, the nurses, other health personnel, and the identities of the hospitals where their experiences occurred.

The findings of this study provided baseline data for future research endeavors related to immigrant Filipinos and contributed to the improvement of nursing care practices in a cross-cultural setting.

CHAPTER 4

RESULTS: PART 1

"ONE OF US" AND "NOT ONE OF US" (*HINDI IBANG TAO AT IBANG TAO*)

A purposive sampling of 13 female and 11 male Filipino-Canadian patients whose ages ranged from 33 to 86 participated in this study. They arrived in Canada anywhere from the 1960s to the 1990s and have lived in Canada for 5 to 40 years. All except one are Catholic. Three hold graduate degrees, 11 have postsecondary degrees, six have high school and/or vocational training, and three have elementary education. Eighteen originated from Luzon, six are from Visayas. None came from Mindanao. These Filipino-Canadians received care in Canadian hospitals for varied reasons, such as childbirth (normal and caesarean), heart problems (angina, dilated cardiomyopathy, congestive heart failure, irregular heartbeat, cardiovascular or cerebrovascular diseases, ventricular bleeding, mitral valve stenosis, and hypertention), upper respiratory diseases (tuberculosis, pneumonia, and lung cancer), urinary tract diseases (hernia, prostate gland, stone in the bladder, and other kidney problems) gastrointestinal diseases (bleeding ulcers and hemorrhoids) and other medical problems (pancreatitis and diabetes). The length of their stays in the hospital varied from 3 days to 2 months. While most of them had been hospitalized only once, some referred to experiences from more than one hospitalization.

The results of this study are divided into two parts. Part 1 has two subsections— "One of us" (*hindi ibang tao*) and "Not one of us" (*ibang tao*). In each subsection, I identify who is considered under each category. "One of us" (*hindi*

ibang tao) includes family members and relatives, friends, and nurses from the same culture. Although nurses from the same culture are typically classified under the "one of us" (*hindi ibang tao*) category, Filipino-Canadian patients' experiences show how they may be considered "not one of us" (*ibang tao*), like nurses from another culture. In section 3, "Shared Human Identity" (*Pakikipagkapwa tao*), I explain how people under these categories switch from being "not one of us" (*ibang tao*) to becoming "one of us" (*hindi ibang tao*), and vice versa.

Part 2 is presented in chapter 5. In sections 1 and 2, I describe the roles and responsibilities expected of "one of us" and "not one of us" in the tasks of "watching over" (*hindi ibang tao ang nagbantay*) and "caring for" (*ibang tao ang nag-alaga*) the Filipino-Canadian patients. In section 3, I discuss the factors that affect the quality of nurse-patient interactions and the depth of the nurse-patient relationships. I also present in section 4 the three dimensions of care provided to Filipino-Canadian patients: physiological, psychosocial, and spiritual. At the end of this chapter is a summary of the findings.

Findings of this study clearly show that Filipino-Canadians are particular about who provides care for them when they are hospitalized. For example, Anita, a maternity patient diagnosed with mitral valve stenosis, was not quite sure how to answer the question, "Who took care of you while you were in the hospital?" She reluctantly referred to the physician but made no mention of the nurses. She thought of relatives and asked if what I meant was a "private person." I asked if there was any private person, and she immediately referred to her husband, who frequently visited her in the hospital.

Anita's indecision puzzled me. In an attempt to rule out the fact that there might be some nuances in the use of the term *care* and who was supposed to render it, I asked whether she was taken care of by nurses. She acknowledged that she had been and recalled that there was one Filipino nurse, whom Anita identified as the head nurse. It amazed me how she seemed confident about the position of the nurse. She vaguely recalled seeing Filipino nurses in another hospital but not in the ward where she was. In her reply, she sounded anxious to see Filipino nurses in both hospitals, but she stressed the fact that no Filipino nurses took care of her in either instance. Yet, in the beginning, when asked if having nurses from another culture or nationality made a difference, Anita did not find that problematic, because she thought that they did what they had to do in the way that they had to do it. However, later in the interview, she said that "other people" from other cultures were not so approachable.

Anita used the phrase *other people* to refer to those who are non-Filipinos. "Other people" is literally translated in the Pilipino language as *ibang tao*—a term more appropriately used in this context as "not one of us." Findings of this study showed that Filipino patients used the phrase *ibang tao* to refer to nurses or other health professionals who are from other cultures and the phrase *hindi ibang tao* to refer to those who are from the same culture—meaning Filipinos. However, *hindi ibang tao* is more often used by Filipino-Canadian patients to mean "one of us"–a phrase that is used to refer to those who belong to the family circle.

Anita, for instance, described her husband as a "private person" and therefore distinct from what she and other Filipino-Canadian patients classified as professionals, such as physicians, nurses, dieticians, laboratory technicians, and other

personnel working in the hospital. This distinction is applicable to the Filipino categories for private persons of "one of us" (*hindi ibang tao*) and for health professionals of "not one of us" (*ibang tao*). However, it is worth noting that although Anita's husband is a non-Filipino, he has become "one of us" (*hindi ibang tao*) because of his spousal relationship with Anita. The question raised, therefore, is, "Can nurses and other health professionals from other cultures become 'one of us' (*hindi ibang tao*), and can family members/relatives become 'not one of us' (*ibang tao*)?" Answers to this question are presented in section 2 of this chapter. In the succeeding sections, I describe the two concepts "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) as they were reflected in the experiences shared by the Filipino-Canadian patients in this study.

"One of Us" (*Hindi Ibang Tao*)

"One of us" (*hindi ibang tao*) is anyone who belongs to the family circle, including the parents, siblings, spouses, children, grandchildren, and relatives who are among the first, second, and third cousins. The findings in this study show that Filipino-Canadian patients were very anxious to have "one of us" (*hindi ibang tao*) visit and/or sleep over in the hospital. In the absence of family members and relatives, friends from the same culture take their place.

Family Members and Relatives

All Filipino-Canadian patients I interviewed referred to either the presence or the absence of families and relatives during illness or crucial moments in their lives (e.g., the birth or death of a family member). Presence of family members is manifested by visits and/or sleeping over in the hospital. These visits are regulated,

and sleeping over depends on the type of ward (i.e., private or semiprivate) or unit (i.e., delivery, operating, emergency, or intensive care unit) and the patients' condition (i.e., acute, chronic, or terminal).

Presence

Private/semiprivate rooms. Findings of this study show that visiting and/or sleeping over in the hospital depended on whether the Filipino-Canadian patients were in private rooms or in semiprivate wards. Individual beds in semiprivate wards were always separated by curtains for patients to have privacy when nursing or medical procedures are done, but the spaces between beds are not large enough to accommodate family members and relatives for an extended stay. Donna, a maternity patient, was so exhausted after the delivery that all she wanted was to rest. In this situation, she greatly appreciated the strict enforcement of the visiting hours from 11 o'clock in the morning until 8 o'clock in the evening. Her husband recalled that visitors were given a maximum of one hour. However, there were other circumstances in which visiting hours were extended. Victor recalled how kind the nurses were to extend the visiting hours until 11 o'clock in the evening when his father, who was diagnosed with terminal cancer, was hospitalized. He also noticed that if there were many people in the room, extra chairs were provided. Family members were not always allowed to sleep in the room, but there were times when the nurses allowed Victor and other members of the family to stay because his father was in critical condition:

> Ah we are given, at night, pillows or *ano* [7]—we are allowed to sleep in the room because sometimes they do not like other people to *ano*—sleep.

[7] *Ano* is a word/expression that is literally translated as "what" but in most instances it is used as "that which is being referred to." This term recurred frequently in the transcribed text to indicate any of the

Anita also recalled her husband's sleeping in the hospital the first two nights when she delivered her first baby but not with her second one because he had to take care of their first child at home:

> [laughing] And I have a private [room] so my husband could stay in the room or other person can stay in the room. If you are sharing with somebody, I think it is not allowed to have another person. I mean another person except you in the room.

She recommended that if Filipino-Canadian patients wish to have members of their family sleep over in the hospital, it is best to get a private room. She also stressed that in both instances she had a private room and they had more privacy.

Waiting rooms. Ester, another maternity patient, noted that although her husband was not allowed to stay at her bedside when she was admitted in the ward, the hospital had waiting rooms where family members and relatives could sit to wait and relax:

> They did not want me to go home because they said my water [bag] has [burst]...so...I'm prone to infections. So I had to stay.
>
> ...Oh I remember my husband wants to...you know, stay in the bed with me in the room and they won't allow it. Like they said that they are not allowed to stay there, but he stayed anyway.

Delivery rooms. In most maternity cases, the husbands brought their wives to the hospital. All of them, except for Laura, had their husbands in the waiting and delivery rooms during labor and actual delivery. When asked if her husband was allowed in the delivery room, Ester said "yes" and even noted that her husband took an active role during the delivery:

> Yeah, yeah o yeah. He even cut the cord and held the baby. They let him. "Daddy it is your...time...you know. Oh your part." They gave him the scissors.

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three instances: (a) when interviewees grappled with the right word to say, (b) when they tried to recall things, and (c) as a euphemism.

Several husbands revealed how thrilled they were with the experience of holding their babies for the first time the moment they were born. Antonio (Anita's husband), for example, recalled,

> When [name of the first child] was born, I was allowed to go right into the delivery room...they thought it was just natural at that point. The pediatrician and the staff came in and washed her up and then said, "here you go Dad its yours." She was 30 seconds old [a crack in his voice]. I will never forget that. But, I think the way the staff at the [name of the hospital] looked after her and did the amniocentesis was good.

Being allowed in the delivery room and assisting in the delivery might be a new experience for most Filipino couples, because in the Philippines, husbands are seldom given the chance to play active roles during childbirth unless the deliveries take place in their homes.

Gina, another maternity patient, truly appreciated the supportive presence of her husband. She found her experience hilarious and yet regretted the fact that she blamed her husband for all her anguish and pain while in labor. She even recalled swearing never to have another baby because of the pain she went through:

> [laughing] I think I was the noisiest in that ward [laughing]. There was a time I was really holding [demonstrating how tightly she held on to his wrist]... because, during the delivery, my husband stayed with me for everything. My husband was there to support. But with my second baby, I really went through great difficulties. *Pinitcharahan* [I yelled]. I told my husband, "you don't feel this, you don't know how my feeling is" [laughing]. My voice was so loud. Maybe, I was so frustrated because the baby won't come out and it was so painful. So I was the noisiest. I know [laughing] I had the loudest voice [laughing].

Intensive care units. Intensive care units are highly specialized areas in the hospital that strictly prohibit visitors. On exceptional situations, they might allow one or two visitors at a time. However, in the case of Thomas, who was just about to have his heart transplant, all the members of his family and friends were allowed to visit

him in the intensive care unit a few hours before he was brought to the operating room:

> All my *kuwan*[8] [families] were already there [ICU]. They were really waiting that day. They would not leave. All the families: my brother, his wife and children, my sister, her husband and children and other friends. Everybody who was close to us were all there.
>
> They were all allowed to go inside. OK, all of you talk [there]. They brought chairs...so we prayed. Everyone already knew. The news spread already. Everyone knew that it was at this time in the afternoon. That time was *ano* at nine. I was already on the way to enter the OR.

Apparently, Filipino-Canadian patients appreciate when nurses allow family members to be at the bedside during critical moments in their stay in the hospital. It is important to know that visits and sleeping over in the hospital with the Filipino-Canadian patients are vital for their well-being. Nurses and health professionals often view these visits as essential for the patients to receive the assurance and support from their families:

> I was really very happy the ultimate solution was coming, at the same time, I was worrying. I was thinking that maybe the transplant will not be successful...eh of course you also have doubts no matter what, isn't it? Even though you know that those who will do it to you are specialists...even though you know and I have seen living proof of those who survived for five years, ten years, seven years, who are *kuwan* still [alive] eh what if it does not work with me eh so [laughing] OK.

However, findings of this study indicate that these visits are beneficial not only for the patients but also for their families, who need assurance and support as well. Thomas was happy that at last his heart problem was going to be resolved and yet experienced the uncertainty despite all the assurance of having experts and a living proof that such a procedure was successful. The question—"What if it does not work

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[8] *Kuwan* is a Filipino expression similar to *ano* that is used to indicate "that which is being referred to." It is used in any one of the instances when someone is (a) grasping for the right word or phrase, (b) recalling something, or (c) using a euphemism.

with me?"—lurked in his mind. His family and friends tried to assure him, and yet it was obvious to him that his family and friends were afraid for him too:

> So I saw all of them with sad faces. Sad but they were trying to make me happy. So it was a bit...a bit...just okay. "You can make it. That is nothing." But I can see in the expressions in their eyes were tears [laughing].
>
> They were really crying. Yes it was like they pitied me...there was even a *eh nakul* "that is nothing" [*baliwala yan*] eh "it is nothing at all [*baliwala*] eh and yet you keep crying and crying there" [laughing]. I was still doing or saying things like that to them. So now [now he was in tears] since that time, they were all facing me like that...my mind was very clear.

Although his family tried to assure him that everything was going to be all right, they could not hide the fact that they were afraid of losing him. He made known to them that he was resigned and was prepared for whatever might be the outcome:

> I said, "the operation might not be successful and this is the last time that we can talk and see each one of you." So I talked with each one of them. Eh I said my last last will and testament [*nagbilin ako*—this was also used later as something left in another's charge]. I thanked all of them my brothers and sisters...to all my relatives and friends for how they care for us.
>
> I also told my wife, "whatever happens to me, do not bury me in the Philippines. It will cost you a large amount. It is enough just there in the ### [name of the cemetery] just there. Just here [Canada]. I will agree to be buried here only and go on with your life" I said, "I entrust to your care the kids [*Ikaw na ang bahala sa mga bata*]". Eh so it was like that. While they were all crying, I touched and kissed all of them one by one [in tears, short pause].
>
> All my wishes—I already told my children, my wife, and my siblings. I said...ay since we were only new here only a few months. You just imagine May, June, July, August, September, October, November, it was only seven months...seven months only. So I said, "help each other prepare...I entrust you will help them [*kayo na ang bahalang tumulong sa kanila*] with whatever they may need just help them [immediate family]"...After all that, I said everything I have to say to them. I thank all of them. I hugged all of them. I kissed all of them one by one until...
>
> They stayed there for a long time...They did not leave me until the time I was about to be brought inside the OR everything was already ready the nurse said okay Mr. (name of the patient) we are all set to go. That was the only time my friends and relatives went home but my children and wife they stayed that night. There is a family room maybe that they *kuwan* where they can lie down like that to relax. So while they were pushing my bed I held the hands of my wife and my children [cough]. I was pushed to the OR until we reached that point that is how far they can go only. I kissed five four three

> children and also my wife and then I said do not forget my last wish [*bilin*] or we will see you a day or so I said [coughing] So I was already brought inside.

The presence of family members is manifested by visits and/or sleeping over in the hospital. These visits are regulated, and sleeping over depends on the type of ward (i.e., private or semiprivate) or unit (i.e., delivery, operating, emergency, or intensive care unit) and the patients' condition (i.e., acute, chronic or terminal). Occasionally, exceptions to the rules are made when the lives of the patients are at risk. The presence of family members is a source of strength for the Filipino-Canadian patients. Some are fortunate to have family members and relatives who are able to come from the neighboring provinces of Canada, the United States, or even the Philippines just to welcome a newborn child into the family, to assist in the care of an ill member of the family, or to console each other when someone died.

Laura, on the one hand, had her parents-in-law come from Calgary when she delivered her babies; and when Lito (her husband) had a heart attack and was hospitalized, she and his sister took turns staying with him in the hospital. Omar, on the other hand, went out of his way to get his son from the Philippines to come to Canada when his wife was diagnosed with and treated for cancer:

> My son, who was left there [in the Philippines] and is still single, was able to come [to Canada] because my wife insisted. So I said to my children, "He is coming...there was this emergency." So we called and called and brought the documents to the doctors in the [name of another hospital] for them to sign and they signed. I paid for his [airline] ticket. It was sent to the Philippines. In two days, my son already received it. He was surprised because he initially did not like. Their mother was really in serious condition. *Sa awa nang Diyos* [with God's mercy] when my son arrived here, he was the one who attended to my wife. I was there in the [name of the hospital].

Apparently, when his son arrived in Canada, Omar and his daughter, who happens to be a nurse, were relieved to have someone who could stay with the ill member of the

family in the hospital. This allowed them to go back to work and/or to have some respite from the pressure of being expected to stay in the hospital after work.

Absence

Fears and anxieties are very real for Filipino-Canadian patients who have their families and relatives, but they are more so for those who have no one to provide them the care and the support they need when they are hospitalized in Canada.

Anxiety. Ester recalled three instances when she gave birth to her children and elucidated the difference it made when she had her mother around:

> Yeah, that's for sure like you never know what to do. Like when I had my first baby, I was panicky because she was crying all the time...whatever you do she cries...My mother was not around. I was crying too because I don't know what to do...we were both crying and I said, "Oh my God" like it is hard and then the second one and the third one were like peanuts...like I can do it and my mom was there.

Ester's mother was in the Philippines when Ester gave birth to her first child. She actually raised three reasons why she was anxious and panicky: It was the first time she experienced having a baby, she did not know what to do, and her mother was not around. In contrast, when she had her second and third babies, she already had a previous experience, she knew what to do, and her mother was there to help her. In addition to the spouses, mothers take an active role in taking care of a newborn in the family. Ester made it clear that having her mother around made a great difference.

Loneliness. Florence, who had to go through a long and painful process of in vitro fertilization (IVF), described the loneliness she felt about not having her husband or any member of her family stay with her while she was in the hospital. She contrasted this with her experience back home (in the Philippines):

> It was lonely there [hospital] at night because my husband had to go home and he has to work and it's lonely. It's not like in the Philippines where someone can stay with you. That time it's just the two of us [she and her

> husband] here [in Canada] so there was nobody to stay with me at the hospital.

When asked whether she had any relatives in Canada besides her husband, she clarified that she had one sister with her but she had to work. At that time, there were only three of them.

Friends from the Same Culture

In the absence of families and relatives in Canada, Filipino-Canadian patients relied on close friends from the same culture to visit, stay, and provide them with the care and support they needed. Sonia, for example, was fortunate to have a Filipino friend who brought her to the hospital for a bleeding ulcer:

> I nearly died because I realized...there was blood in my bowels. My bowels were black. Now I kept drinking and drinking milk but my bowels were still black and then I was already feeling dizzy. It was a good thing I had a friend who brought me to the hospital. When I got to the hospital, I was placed immediately in the stretcher. I realized later that I was losing a lot of blood already [laughing]. They immediately placed dextrose and also a bag of blood. I was able to consume four bags.

Sonia reiterated the anxiety described earlier by Ester, when her mother was not around to help her, and the loneliness previously expressed by Florence, when neither her husband nor her sister was available to stay with her in the hospital. In spite of the presence of a friend, Sonia felt alone:

> There were times, at night, when I could not sleep because I was alone by myself. I remember my family because *biro mo* [can you imagine] for 7 days... after two to three days, I was still feeling the same way. There was no pain at all, but when I moved my bowels, it is still black. *Ay nakul* [interjection from *Ina ko!* direct translation of the Spanish *Madre mia!*]

> It was December then and the snow was so thick. I might die here, I did not have my family here, I was lonely. I could not sleep. The nurse said, you drink this *ano* [that which is being referred to] they would bring me Demerol...I was thinking I might get addicted to this...I am not going to take this. What they did was to call the doctor. They put it on my IV. It already went straight inside. So you could not refuse anymore. I was able to sleep already.

Having to be alone was among the greatest challenges most Filipino patients struggled with while in the hospital. Filipino-Canadian patients felt lonely and experienced many fears and anxieties that disrupt their physiological functions such as eating, sleeping, and eliminating. When this happens, they are reluctant or even afraid to take remedies that are unfamiliar to them, such as sleeping pills, and this can be interpreted by nurses and other professionals as being difficult or noncompliant.

Another example is Ignacio's experience after his gall bladder surgery:

> The male nurse that looked after me was a Filipino. I remember now that I was suppose to within...so many hours after surgery I was suppose to be able to... pass water but I couldn't. I think it was the after effect of the anesthesia or something. I just couldn't as hard as I tried I couldn't and the male nurse said okay then we have to use the catheter. I kept...Oh...I think I can do it...I think I can do it. Two hours later I still couldn't do it so I said OK and that was...the delay was...my fault not his. I was trying to see if I could do it on my own but like he was saying that is the after effects of the anesthesia that sometimes although it feels like you have the control but really it is not there. But I...I was a little *matigas ang ulo* [can be translated as "hardheaded" or "stubborn"] so [laughing].

Refusal to comply with the nurses may upset the Filipino-Canadian patients and lead the nurses to believe that the patients are hardheaded, stubborn, or noncompliant, but this has more to do with their fear of trying new or unfamiliar things. Ignacio noted that the nurse who looked after him was a male Filipino nurse. Filipino nurses, especially if they come from the same ethnic background as the Filipino-Canadian patients, were often considered "one of us."

Nurses from the Same Culture

It is evident from the previous sections that Filipino-Canadian patients expected and relied on their spouses, parents, siblings, or children, whom they considered "one of us" (*hindi ibang tao*), to visit, sleep over, and provide care and support when they are in the hospital. In situations where they had neither families

nor friends, they were very anxious to see hospital nurses from the same culture, who were considered "one of us" (*hindi ibang tao*) in most instances.

Urlando, who was diagnosed as having angina, preferred to have his by-pass performed in Canada but would have preferred Filipino nurses to care for him. When asked why such a preference for Filipino nurses, he said,

> The nurses here [Canada] never asked me about my family. In the Philippines after a while, the nurses already know all my sisters, cousins, and aunts who frequented the hospital. They even got to know their names but here [Canada] you are not even a person to them.

The personalized approach of Filipino nurses was evidently valuable for Urlando. He cited, for example, how his mother was referred to as grandma *lola* by the nurses when she was hospitalized:

> She [mother] shared with the nurses the food we brought for her. My mother and the nurses got to know each other so well and after a while I also got to know them. At times I don't remember the names nor the faces of the [non-Filipino] nurses I met and took care of me but I can tell you that I know the names and the faces of the [Filipino] nurses who took care of my Mom.

Obviously, it was important for Urlando to be treated as a person with a name and a face. For him, the depth of relationship established by the nurses with the patients and their families was manifested by how far they had known each other during the interaction and how well the patients and their families remembered the nurses long after the hospital experience. He elucidated further:

> Here [North America] we live in a society where social ties are weakened. Our job defines our relationship with others. Or you can see these people here who live in apartments hardly know their names. Or you can make comparison between rural and urban Canada. Whereas in the Philippines, we are more caring *maasikaso*. It seems as though they are more concerned not just you as a patient but you as a human being. Something of that sort. You should not say... this is a critique of...it is just that human relations here are not as personal as developing and underdeveloped countries.

Urlando maintained that the behavior of people is reflective of the society in which they live. He associated the quality of care and the depth of human relationships with

the country's level of development. He pointed out that people in more developed countries are less caring and less personal in relating with one another. He demonstrated this by comparing the hospital food service he experienced here in Canada and in the Philippines:

> When the food is brought into my room, [and] the question—how are you—is perfuntory. I am always tempted to ask when anybody ask—how are you—"Why do you really care?" But then, when you turn that around, "Who the hell am I any way to them?" They don't really matter. So I suppose it is accepted here, but in the Philippines, the patients will complain *aangal.* "Why is the nurse like that?" Why did the nurse just toss the food on the table?" The patients will reproach the nurse [laughing] won't they? The patient will bring this issue to the attention of those in authority. Especially if the patient has "connections" in that hospital or will raise this incident to the doctor or to the supervisor. See how different the two approaches are?

Urlando perceived the gesture of the nurses to ask—how he was—as merely perfunctory. It may sound perfunctory, but in North America this is one way of greeting people, and the responses most people make are usually in general terms. He further perceived that as a patient when he was asked, "Were the nurses from other cultures caring and nurturing?" His answer was, "I will have to say no but they were efficient." When asked what he expected of them, he said,

> Well, were they really concerned about me as an individual? As a human being? Were they really concerned about my health? They were professional but they were [pause]... there is an absence of human touch...I don't know...am I making myself clear? I guess they were performing their duties but they do not go beyond what is required of them. But I really did not expect it because first of all we live in a society where...it is an industrialized society where the human bonds are not as...as cohesive as those in under or developing countries where human relations are more personal.

Filipino-Canadian patients expect a personalized approach from nurses, more so from Filipino nurses, who come from the same culture. In his examples, Urlando talked about food service and human touch. These are two salient points that I will explore

extensively in the subsequent chapters particularly in the psychosocial dimensions—in particular, the language of food and the language of touch.

"Not One of Us" (*Ibang Tao*)

In the previous section, I explained how Filipino-Canadian patients classified family members and relatives as private persons and, therefore, considered them "one of us" (*hindi ibang tao*). In contrast, they classified nurses and other health professionals, either from the same or other cultures, as "not one of us" (*ibang tao*). Findings of this study showed that Filipino-Canadian patients relied totally on members of their family, whom they considered "one of us" (*hindi ibang tao*), and seldom needed assistance from the nurses, whom they considered "not one of us" (*ibang tao*). In this section and succeeding subsections, I will describe further how Filipino-Canadian patients perceived nurses from the same and other cultures, and the roles they played, responsibilities they assumed, and tasks they performed.

Nurses from the Same Culture (Filipinos)

Filipino-Canadian patients commonly referred to Filipino nurses as "one of us" (*hindi ibang tao*) because they come from the same culture. However, there were several instances when Filipino-Canadian patients considered them "not one of us" (*ibang tao*) because these Filipino nurses possessed characteristics such as being *suplada*[9] (conceited and arrogant) and *bastos* (rude).

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[9] *Suplada* originally came from a Spanish verb *soplar* meaning *inflar*, or "blow," but in this context it is used as an adjective to describe someone who is conceited and arrogant. A Spanish word synonymous to *soplada* is *presumida* – an adjective related to vanity and therefore perhaps equivalent to the English terms *conceited* and *arrogant* (Panganiban, 1972).

Suplada (Conceited and Arrogant)

In the previous example, Thomas pointed out the impersonal food service he experienced in the hospital. In a similar fashion, Paula remembered how she was ignored and disregarded by a Filipino hospital worker who served her a tray of food:

> Yeah, yeah, yes 10 years ago. I can recall that experience with a Filipino worker. She knew I am a Filipino, I was seated. And I knew her but we are not friends. I knew her, she knew me. You know what she did? Bringing the tray of food, she just put it there and turned her back right away and left and when she got [also] the tray she just also [mimicking that she just turned her back]. I don't know... Filipinos, if that's how they treat but if she were White, "Hi!" [mimicking again] very special attention. That's what I think, sometimes you are taken for granted.

Paula stressed that the Filipino worker was aware she was a Filipino and that they both recognized each other ("I knew her, she knew me"), yet the unexpected indifference on the part of the Filipino worker was definitely unacceptable to her. Paula expected to be regarded warmly by the Filipino worker but instead felt taken for granted, and she contrasted this with how a White nurse would have greeted her. Paula obviously felt disregarded and ignored. *Suplada* was, therefore, used in this context to refer to someone who treated another person in an impolite and rude way. Paula traced the Filipino worker's behavior as resulting from being *nahihiya*[10] (ashamed of) working in the hospital, thus disclosing her own pride in being a teacher and a school principal. Her interpretation of the Filipino worker's behavior reflected how highly she regarded the teaching profession. Paula obviously viewed serving food trays in the hospital as lesser and thought that the Filipino worker was perhaps ashamed of doing her job.

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[10] In the Philippine language, the word *hiya* is used for both "shy" and "ashamed."

Another way of interpreting this situation was by asking why Paula expected to be regarded highly by others. Paula had been a school principal in the Philippines. Apparently, she expected the Filipino worker, whom she described as a teacher in the City Schools in the Philippines, to treat her in a special way. Was the Filipino worker truly ashamed of her job in the hospital (i.e., kitchen staff) because it was below her qualifications as a teacher, or was Paula merely projecting herself as a point of reference in this situation? Because school principals have always been highly regarded in the Philippines, it was more likely that she expected the same treatment from other Filipinos even if they were no longer in the Philippines. Nevertheless, she described positively the care as being *maayos* (orderly), the Filipino workers in general, and the Filipino nurses in particular as being *masipag* (hard working), although also negatively as being *suplada* (conceited or arrogant) to their *kapwa*[11] (fellow) Filipinos.

Remy, another Filipino-Canadian patient, described a Filipino nurse as being *suplada* (conceited) and, therefore, considered her "not one of us" (*ibang tao*). When asked, "Among the nurses who took care of you, is there anyone who stand out in your memory?" her reply indicated clearly who it was that she liked and disliked:

> Yes, I do not know her but she is *suplada* eh. Specially those Filipinos, it is not to *ano* [criticize] no. It appears like they are not...the Whites are better sometimes to *kuwan* [deal with]...it looks like they respect you, but if they are Filipinos, I do not like them. One time at night, it was time for me to take my medicine...I still have to go to the nursing station to ask for my medicine.
>
> Yes, [I press the buzzer to call them] because at that time there was a crisis already. There were not many nurses that go on duty. That was '91. Things were getting hard for the nurses here because they were already leaving. Even my daughter has already left this place. That is probably why things

[11] *Kapwa* was used in this context to mean merely "fellow Filipinos." However, it also identified a shared Filipino identity that allows one to distinguish whether the "other" is "one of us" or "not one of us." The word *kapwa* emerged repeatedly from the data and is explored further in Section 3.

> were like that. I can not blame them because they were already overworked at that time. But that was what happened to me. If it is already time for me to take my medicine and they do not come, I go to the nursing station and ask it myself. That is the only time they get it for me.

Contrary to Paula, who knew the Filipino worker, Remy did not know the Filipino nurse, and yet both had a similar perception. Paula perceived the Filipino worker as being *suplada*—impolite and rude in her manner of serving and collecting the food tray. Remy likewise perceived the Filipino nurse as being *suplada*—disrespectful and rude. Remy also remembered that the nurses forgot to bring her medication and explained that perhaps the reason for such behavior was the fact that, at that time, the hospital was understaffed.[12] When I asked Remy to describe, "In what sense were the Filipino nurse *suplada*?" and to cite instances "when you did not like how you were treated," she replied,

> When they seem to ignore you. Yes. When you ask for something and they do not pay attention or take notice. So it is not really to *ano* [criticize] because I am also a Filipino. I like better the Canadian nurses, *eh*. That is my experience when I was in the hospital *ha. Ahh eh* I just do not know. Whatever it is that they are *kuwan* [trying to find the right word] but they are different eh different.

Both Paula and Remy apparently felt disregarded, ignored, and unattended, and therefore preferred Canadian nurses, whom Remy mentioned earlier as being respectful. Remy did not know why the Filipino nurses behaved the way they did but noted the difference. Although she did not raise this issue with her daughter, who was also a nurse, she tried to make allowances by comparing her perception of nurses' working conditions here in Canada with what her daughter was experiencing in the United States:

> According to her, it is because there is so much work especially for her. She was in the pediatric, at that time, with the children and babies. She was *kuwan* [trying to find the right word to say]...she chose the night shift.

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[12] Nurses were being laid off due to the health cutbacks.

> According to her, "it is really hard even in the States. The nurses are really having great difficulties."

She continued:

> *Eh* no, my reason also is because that is the profession they chose, so they need, therefore, to go to the patients when it is really the time for them to take their medicine, isn't it? *Eh* but that was not the case. *Eh* I myself have to go [to the nurse's station] because I am afraid that my heart will again *kuwan* [pump the way it did] [voice a little shaky] that is why I come to ask for my medicine.

She expected the nurses to be conscientious about their responsibilities, especially in monitoring and administering her medication. Remy did not sound impressed by nurses who came from her own culture when I asked her the question, "Was there any nurse with whom you felt most 'comfortable' (*napalagay and loob ninyo*)?"

> *Eh* for me, there was no one *eh* because the only thing [*kuwan*] that I seemed to be comfortable with [*napalagay ang loob*] were the Canadian nurses, at that time, because they were very kind to me then *ano*...eh now eh no, because they seemed overworked already. So they no longer do the thing [*kuwan*] like that. *Eh* ...especially if the duty is at night because they are alone by themselves but they cannot be blamed for it. However, that is what I seem to observe with them why they are like that.

Although she tried to rationalize that the hospital was understaffed and the nurses were overworked, she was certainly dissatisfied with the care given to her.

Bastos (Rude and Discourteous)

Carla, a maternity patient diagnosed with myatonia congenita and a possibility of malignant hypothermia, also recalled how most of the nurses who took care of her immediately after her Caesarian section were very caring, except for one Filipino nurse, whom she described as *bastos* (rude, discourteous, or ill-mannered):

> I was really *asikasong-asikaso* [well attended to] which I appreciated and then there was one...all of them I can say were very very kind in general. I can not go into specifics of mentioning them one by one but all of them seemed very positive. That is how I evaluate all of them except for one. That nurse happened to be a Filipino, unfortunately. I am sorry to say. I really did not know she was a Filipino but I saw her name [surname of the nurse]. She seems Chinese. She was really *bastos*.

Because Carla had limited mobility and was suffering from incontinence, she decided to go to the washroom just before the nurse came to insert intravenous fluid and to transfuse blood. When the nurse arrived, Carla told her that she wanted to go to the washroom, but the nurse suddenly shouted at her, "Why go to the washroom now? Why just now? Why did you have to wait until I came?" Carla expressed how offended she was by the rude and discourteous treatment she received from the nurse. She also described how much it hurt her when the nurse inserted the needle:

> She was really very rude. I really did not want her to do anything with me. I expressed that I was so offended and then I asked for another nurse and I said that I did not like her to do anything with me—I didn't want her to take my blood. I said, she was very discourteous...There was no one else who could do it. So she had to take it anyway. Oh it was really so painful. All throughout the period, I was having blood transfusion. Really, all throughout I had them it was like...It was like *nakasaksak sa akin na kutchillo* [a knife stabbed inside me]. Perhaps because of anger, and then *parang nagdadabog*] seemed annoyed or irritated] *ginanoon ako basta eh* [she did it just like that].
>
> That was my worst negative experience during my stay which was almost two weeks in the hospital. They were all busy eh and I don't know, it didn't seem...I told one nurse if it was possible to send me another nurse but they didn't send me another one. She was still the one who came so I had no choice but to allow her but that really stood out because she was very different from all the other nurses ya.

Both Remy and Carla observed that the nurses were all busy. Was this a justifiable reason for being *suplada* (arrogant) or *bastos* (rude)? On the contrary, Brenda found the Filipino nurses to be accommodating, especially to patients who were having surgery for the first time:

> [The surgery] went well. It went well. It was an older surgeon that did that procedure and it turned out all right. And...there was another Filipina[13] there who looked after me. Of course, if your baby is a Filipino you've got tons of attention. Yes [laughing] well specially if they know [it's] your first time. So [they ask,] "How are you feeling?" "Do you need anything?" "Are you comfortable?" Do you need help to go to the bathroom? And it was the same

[13] When one is referring to the people of the Philippines, the correct term to use is Filipinos, Filipina if a female, and Filipino if a male. In this study, the term Filipino is used generally to mean female unless the quotes specify the gender-differentiated noun. In referring to males, then the descriptor *male* is added, e.g., male Filipino nurse.

> thing when I had my baby. Of course, my godmother, when we were married, she was there [hospital] too. She was looking after me and said "How are you now?" and then she'll do whatever she has to do. Yeah, yeah, so that's what I found out. If your *kuwan* [nationality] is Filipino, they really...only if you are Filipino, they tend to [give you more attention]. I think it is the same thing with the Whites. I think they are the same *pagka yong kapwa nila Canadian ya* [but more so to their fellow Canadian like themselves].

She recalled two Filipino nurses who looked after her. One of them happened to be her godmother, who was working in the same hospital. The distinction she made over the relationship she had with the nurse, who was her godmother, meant that she considered her "one of us" (*hindi ibang tao*), whereas the other Filipino nurse was "not one of us" (*ibang tao*). She also stressed the fact that special attention was given "only if you were Filipino" and thought that Canadian nurses would do the same with patients who were their fellow (*kapwa*) Canadians. She paralleled this to what Filipino nurses would do to patients who were fellow (*kapwa*) Filipinos.

Besides kindness, respectfulness, politeness, and courtesy, willingness to accommodate seems to be another quality sought by Filipino-Canadian patients from nurses whether they were from the same or from other cultures. Gina thought that nurses in Canada were generally diligent and devoted to their work. She observed that there were nurses who worked as long as 12 hours. She thought that this was perhaps the reason that nurses got tired and found ways of relaxing from pressure. For her, a good nurse is one "who is really *tapat* [faithful or committed] to her work. Instead of doing her job 100%, she is going to do it 120%." She cited, for example, two Filipino head nurses whom she found to be an excellent example of this:

> The Filipino nurses here are really *magagaling* [good or excellent]. Oh they really really do their work. You can see how they work. There is one nurse, for instance, in [name of the hospital]. She is already a head nurse. There [were] two head nurses...When she really works, she really, you know, focus herself in her work. Yeah, you won't see her *paeasy easy* [easy going]. That's typical perhaps among Filipinos, eh, like perhaps in whatever kind of work that you find them.

> And [also] even if they say we are very panicky but we are serious about what we do in our work like when you say work it really means work and when you say play it is really play. [Panicky] is like you always want to finish the work at once like, you know, but it is like we are really so much devoted to our work. It is seldom that you see a...except those who are from another *lahi* [race or, in this context, from other cultures] like those who come from South East American like those who are from Chile those from South America are the laziest. Latin American or others who are White. Yeah others not many. Unlike nurses from the Philippines, there are many of them on duty.

Gina confirmed Paula's observation that Filipinos in general and Filipino nurses in particular were hard working. In contrast to nurses from other cultures (e.g., Southeast Asian and Latin American), Filipino nurses are known to be more serious (not easy going) and devoted to their work. She explained that Filipino nurses are "always wanting to finish the work at once" when I asked her, "What exactly do you mean when you described Filipino nurses as being "always in a panic to finish their work?" She equated this with being devoted to one's work.

In summary, findings of these study showed that Filipino-Canadian patients found Filipino nurses to be more serious and devoted to their work than nurses from other cultures. Some Filipino-Canadian patients, however, found some Filipino nurses "disrespectful" and "arrogant" (*suplada*) or "rude" and "discourteous" (*bastos*) and therefore preferred nurses from other cultures. Being polite, respectful, kind, courteous, approachable, and willing to accommodate were important qualities that Filipino-Canadian patients sought from nurses regardless of whether they were from the same or from other cultures. Nurses from the same culture—Filipino nurses who, apparently, did not demonstrate such qualities—were considered "not one of us" (*ibang tao*). Filipino-Canadian patients obviously expected more from nurses from the same culture, as they were their fellow Filipinos (*kapwa Filipino*), but further

speculation indicated that a parallel treatment might be true of Canadian nurses toward their fellow Canadians. Other experiences with nurses from other cultures will be presented in the next subsection.

Nurses from Other Cultures (Non-Filipinos)

Nurses from other cultures in this study refer to non-Filipinos. The interviews showed that Filipino-Canadian patients referred to them either by skin color (i.e., White or Black nurse), by nationality (Canadian, East Indian, North American, Southeast American, Latin American, or Chinese, etc.), or by race (i.e., Caucasian or Asian).

In the previous section, Anita described nurses from other cultures as being less approachable. In the prior subsection, however, Paula and Remy expressed their preference for nurses from other cultures because they experienced them as being polite, kind, respectful, courteous, approachable, and willing to accommodate. Karen's experience showed both the positive and the negative sides of being cared for by nurses from other cultures. She read from her personal diary an unpleasant incident that happened when she was admitted to the geriatric unit for balance problems. She thought that her experience with the Black nurse was an example of elder abuse and, perhaps, racism. In the end, another nurse, who was White, came to comfort her:

> I learned before that if things like this happened you have to put them down. Write them down so that when somebody, you know, wants to know about it then I can always...oh here...[finding the page where she wrote the incident down] Elderly abuse: Physical and emotional. Can I read this over?
>
> February 12 Saturday yeah, 9:30 to 10 am, I started feeling to empty my bladder. I was going to call for assistance when a RN came to look after [name of a patient], the other patient there. On her way out, I requested her to help me. I was in bed so I brought my feet down. She brought my feet down, stood me up straight and expected me to walk. I informed her that I

> could not do it by myself. "Why?" And I said, "doctor's advice." "You can do it." And the nurse took the walker. She took the band and tied around me and said, "Go ahead walk." My legs gave way. The walker had become as unsteady as my whole body. Then I said...she was pushing me into the bathroom. She was just unbearable. She tried to grab the bar to help seat me on the commode. She grab my right arm and abruptly put it back on the walker...She forced me to stand, turned me around and grab my pants and underwear and pushed me to seat. I could not see anymore. "You are not being nice to me. You are harsh. You are rough," I told her. I was already crying out loud. I said, "I want to go back to my bed" and then the nurse said, "No, you are not." "You are not nice to me. I want to go back to bed." She held on to me, not letting me go.

Karen described the Black nurse, on the one hand, as being harsh, rough, and not nice at all, whereas the White nurse, who came into the room to comfort her, was exactly the opposite:

> When all this was going on [name of a White nurse] came in then I said to [name of the patient]: "She is not nice to me. She is harsh. She is rough. She is rough handling me... on the..." the head nurse said, "You can walk. The chart over there said you can do it." The chart at the bed and I just told her, "That is not my chart." I was shouting this time. "It is Mrs. [name of the patient] that is not mine." Mrs. [name of the patient] was the...because I was in the special room when a patient came. She was more serious that they moved me to the geriatric unit and the bed I occupied was the bed of Mrs. [name of the patient] who was just recently released.
>
> There was a chart there. And then she was completely stunned when she saw it and then I kept repeating, "why are you doing this to me? Is it because I am not Canadian?" And then the nurse said, "it has nothing to do with it." Realizing her fault, she just...[participant a little teary and a pause] she just...left. I think and that's it. And then I was crying and crying then when ah...[name of the nurse] came in and then tried to comfort me she was really nice...that nurse.

Because of her emotional state at that time, it was hard for Karen to discern whether her experience was indeed a mere shortcoming on the part of the head nurse, who did not check the chart, or whether the nurse's behavior was driven by racial discrimination. Early on in the interview, Karen stressed the fact that the head nurse was Black (and, therefore, there was an obvious racial difference). It was also likely that because of her age, Karen expected to be regarded with kindness, respect, and courtesy. It was also possible that because of her economic status and previous

position in the Philippines, she was accustomed to special treatment and, therefore, expected the same treatment from the nurse, who was obviously younger and perhaps less experienced than she was. Elderly Filipinos generally enjoy a privileged position in the Philippines.

In conclusion, Paula's, Remy's, and Karen's accounts raised salient points that nurses from other cultures must consider in the care of elderly Filipino-Canadian patients. First, most elderly Filipino-Canadian patients have experienced being looked up to as authority figures and are well respected both inside and outside the family; therefore, they expect the same regard from nurses whether they come from the same or from other cultures. Second, most of them experienced being well looked after by family members when they were sick or handicapped and, therefore, expected to be looked after in a similar fashion by nurses from the same or other cultures. Filipino-Canadian patients, however, expected more from nurses who were from the same culture. Third, Filipino-Canadian patients appreciate nurses who are polite, respectful, courteous, approachable, and willing to accommodate regardless of whether they are from the same or other cultures.

Shared Human Identity (*Pakikipagkapwa-tao*)

The first part of this chapter clearly shows that Filipino-Canadian patients used the expression "not one of us" (*ibang tao*) in two ways. They used "not one of us" (*ibang tao*) to refer to "another person" or "other people" either (a) from the same culture who are not members of the family or (b) from other cultures who are not members of the family. It was also noted that Filipino-Canadian patients usually rely on "one of us" (*hindi ibang tao*)—those considered as belonging to the family circle

and especially those family members and relatives who are professionally trained as doctors and nurses—for their personal needs. In the succeeding subsections, I will discuss how these categories shift in the process of nurse-patient interaction.

We know from previous accounts that spousal relationship is one way for someone who is "not one of us" to become "one of us." The questions raised, however, are the following: (a) How do professional nurses who are "not one of us" (*ibang tao*)—meaning nonmember of the family and are from the same culture—become "one of us" (*hindi ibang tao*)? (b) How do professional nurses who are not one of us (*ibang tao*)—meaning nonmember of the family and are from other cultures—become "one of us" (*hindi ibang tao*)? and, conversely, (c) How do professional nurses who are "one of us" (*hindi ibang tao*)—meaning a member of the family and are from the same culture—become "not one of us" (*ibang tao*)? In this section, I address these questions by bringing to light another Filipino concept, referred to as *pakikipagkapwa-tao* (shared human identity). In a more general term, *pakikipagkapwa* means the ability to identify with someone's humanness. Filipino-Canadian patients in this study, however, used the word *kapwa* to identify with a nurse's Filipino identity or, in some instances, to identify with a nurse's particular characteristic or experience that makes up one's being. An important aspect, therefore, in the process of *pakikipagkapwa* is that two or more people share such an identity.

Nonmember of the Family and Those from the Same Culture Become "One of Us"

I noted earlier that Filipino-Canadian patients were always anxious to see Filipino staff in the hospital. In contrast with Anita's vague memory of seeing

Filipino nurses when she was hospitalized and her confidence that the one she saw was a head nurse, Ignacio vividly recalled all the Filipino nurses he encountered in the hospital. He also observed that the hospital maintenance personnel were mostly Filipinos:

> One thing I noticed there, we had one male nurse who is a Filipino. Not only that, the maintenance staff was also mostly Filipinos. Like we had Filipinos in that hospital. Even now... even the...this hospital here, they still have Filipinos here with their staff there.
>
> I said, well I'm glad to see that I think the [name of the hospital] at that time, I think we...the...the household staff were mostly...from what I can see, they are mostly Filipinos and some of the nurses were Filipinos and I won't be surprised if there was a Filipino doctor there. Although I don't recall seeing one but I won't be surprise if there was a Filipino doctor there.

Both Anita and Ignacio took note of the positions or rankings of the Filipinos they saw in the hospital. However, regardless of ethnic, educational, and economic background, Filipino-Canadian patients were very anxious to see Filipino nurses in the hospital. They felt a great sense of relief knowing they have someone to talk to in their first language and someone to relate to when they were lonely or someone they can rely on when they felt helpless.

Several accounts indicated that Filipino-Canadian patients and their families felt a sense of relief finding one or more Filipino nurses during their stay in the hospital. Lito and his wife, Laura, for example, recalled the time when Lito accidentally moved his bowels in bed. He was just about to put his feces in his mouth when Laura saw him and was, therefore, able to prevent him from doing so. After being unconscious for several days, Laura described Lito's state of mind as being

disoriented and confused.[14] Lito explained later that the whole experience was like a dream. He dreamt that he was in France and was eating at a party.

Laura had to call an orderly for help. She expressed her relief that one of the three orderlies who helped to clean and change Lito was a Filipino. It meant a great deal to Laura to find Filipinos among the hospital personnel, as she had only her sister-in-law and her cousin to relieve her when she went to work. This sense of relief was even more evident when the Filipino-Canadian patients did not have relatives in Canada. Nurses from the same culture are, therefore, considered "one of us" (*hindi ibang tao*) even if they are not members of the family, because they are *kapwa Pilipinos*—meaning not only are they fellow Filipinos, they share the Filipino identity.

In addition, Florence recalled two Filipino nurses when I asked her one of the follow-up questions: "From your experience of being hospitalized in Canada, is there any nurse who stands out in your memory right now?"

> There are two Filipino nurses. I guess it's because we're the same. We came from the same country so they gave me special...you know, extra attention. They tried to give extra attention to the needs of my husband as well. Like "Oh I'll give you pillows. I'll give you this." You know, because they understand the culture. Sometimes, my husband would sleep during the weekend right, so then they provide as much comfort as possible to him.

The two Filipino nurses stood out in Florence's memory because she and the two nurses were "the same"—meaning all three were *kapwa Pilipino*. Although they do not necessarily come from the same ethnic background or from the same educational and economic status, all of them came from the same country and openly accepted and shared their Filipino identity; hence, they understood each other's culture. She also perceived that the two Filipino nurses gave her special attention because they

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[14] Lito was diagnosed as having a blood clot in his brain, which made him disoriented.

were culturally sensitive to her needs as well as to those of her husband. Strictly speaking, the Filipino nurses, although from the same culture, were "not one of us" (*ibang tao*) in the sense that they did not belong to the family circle; they were considered "one of us" (*hindi ibang tao*) because Florence felt that they shared her Filipino identity. This sharing of identity is a process known among Filipinos as *pakikipagkapwa*.

In the examples given above, Lito and Laura found in the Filipino orderly a *kapwa Pilipino* in the same manner that Florence found two Filipino nurses standing out in her memory because they were *kapwa Pilipino*. Panganiban gives the words "both" and "fellow-being" as translations of *kapwa*. The phrase "they were *kapwa Pilipinos*" in this context may be translated as "Like me they were also Filipinos" or "They were fellow Filipinos" or "They were both Filipinos." Therefore, it made sense that, from among the nurses who took care of Florence, those two Filipino nurses stood out in her memory, because they were actually *kapwa Pilipino*—meaning they were all the same. They all shared a common identity. They understood her within the context of their culture; hence, they were culturally sensitive to the Filipino practice of having someone stay with the patient while in the hospital. In the absence of family members, these two Filipino nurses dropped by her room during break time and before or after their shifts to keep her company.

Florence had a sense of having a *kapwa*, not because the Filipino nurses accorded her such status but rather because of their common awareness of their shared identity. "We were the same," she said. In other words, she saw no difference between herself and the two Filipino nurses and, therefore, acknowledged they were

the same. Although the two Filipino nurses did not belong within her family circle, Florence felt they were "one of us" (*hindi ibang tao*) because she was aware that they shared her Filipino identity. In the Philippine language, this is what is known as *pakikipagkapwa*—the sharing of identity that allows anyone who is not a member of the family to become "one of us" (*hindi ibang tao*).

Nonmember of the Family and Those from Other Cultures Become "One of Us"

Sharing of human identity is also possible for people who are from other cultures. In delivering her second baby, Florence experienced *pakikipagkapwa* with a Black nurse, who was an immigrant like her. Florence and the nurse recognized and acknowledged those things that are common to both of them—this is referred to as shared identity (*pakikipagkapwa*), which allowed the nurse from another culture to become "one of us" (*hindi ibang tao*) despite being "not one of us" (*ibang tao*):

> Because of the complexity and the seriousness of my situation, they had to assign one nurse, who had like 100% attention, to me. There weren't many Filipino nurses [in that hospital] and a lot of them were Caucasian and I remembered this Black nurse...who was very very nice. I think it was because she is not Caucasian and she is able to feel with me. She probably sympathizes with me who like her is from a different culture and had to move to Canada. She was so nice and a couple of the nurses there were really nice. But I kind of miss the relationship I had with all the nurses, who took care of me in the other hospital when I gave birth with my first baby, who kind of knew me.

Florence perceived that because the Black nurse was, like her, not a Caucasian, she was able to feel for and sympathize with Florence, who also is from a different culture and an immigrant to Canada. Florence perceived three aspects that they shared: They were both (a) non-Caucasian, (b) from other cultures, and (c) immigrants to Canada. In this example, the three aspects she pointed out were all essential components of their "sharing of identity" *pakikipagkapwa*. They both shared the identity of being Canadian immigrants.

Florence is able to regard the two Filipino nurses and the Black nurse as *kapwa*. In both instances, it is evident how *pakikipagkapwa-tao* encompasses the two concepts "not one of us" (*ibang tao*) and "one of us" (*hindi ibang tao*). Evidently, the ability to identify with someone is more than the ability to sympathize—it is the ability to feel with the other person. In *pakikipagkapwa*, both the nurse and the patient share one or more aspects of their identity.

Florence missed the relationship she established with all of the nurses in her previous hospital experience. This indicated that she did not disregard the fact that a deeper sense of knowing was still a prerequisite if one is to become "one of us" (*hindi ibang tao*). Such knowing allowed a familiarity that was made possible by the length of time she stayed in the hospital. Such knowing also allowed a level of *pakikipagpalagayan loob* (mutual trust) to develop between Florence and the Black nurse. In the case of the two Filipino nurses, there was a higher level achieved, and that is known in the Philippine language as *pakikiisa* (oneness and full trust). *Pakikipagpalagayan-loob* and *pakikiisa* are two levels of interpersonal relationship that patients and nurses can try to attain as they interact with each other. If the patient and the nurse have reached either of these two levels, then they recognize the fact that they are *hindi ibang tao* (no different from each other) and therefore recognize that one is a *kapwa* to the other (one shares the identity of the other).

Pagtutunguhan is a Filipino term often used to refer to all levels of interaction, including those mentioned above. However, most Filipino-Canadian patients preferred to use *pakikipagkapwa* because it not only refers to all levels of interaction but also indicates an idea, value, or *paninindigan* (conviction) that they

recognized and upheld. *Pakikipagkapwa* enabled Florence to trust the nurses who took care of her because she was confident that the nurses were able to identify with how she felt, as they shared a common being (e.g., being a Filipino or being someone who is from another culture). In her dealings with the two Filipino nurses and the Black nurse, Florence perceived that they accepted and dealt with her as an equal. Florence obviously missed the nurses from the first hospital because they had gone past the level of *pakikitungo* (relatively uninvolved superficiality) to that of *pakikiisa* (identifying with). How the patients and nurses smoothly move from one level to another is important if one is to interact with Filipino-Canadian patients. Florence was able to do that because she stayed in the hospital for a long time.

Reviewing previous examples of Filipino-Canadian patients who had unpleasant experiences with nurses, whether from the same or from other cultures, such as Paula, Remy, Carla, and Karen, I infer that they were actually expressing the same thing: They felt disregarded, ignored, and mishandled. Perhaps they would have felt better if the nurses treated them as fellow human beings (*kapwa-tao*), which meant showing a regard for their dignity and their being.

Members of the Family and Those from the Same Culture Become "Not One of Us"

Ester recalled how her sister, a nurse, was very involved with the direct nursing care of their father, who was in and out of the hospital because of lung cancer:

> Oh, it's on and off like he was there two months, a week or something...I can remember when he was there in February and as I said, like I wasn't the front line unlike my sister who is a nurse was there who take care of him and mostly those nurses in the station were all known to her. So every time my Dad needs something she knows. She knows what is going on. She knows what to do, you know, and she always do it herself or she gets somebody to help her out.

Although they took turns "watching over" (*bantay*) him in the hospital, it was her sister who took the lead role in taking care (*alaga*) of him. Their father and the whole family completely relied on her for two reasons: She was a member of the family and was, therefore, one of us (*hindi ibang tao*), and she was professionally trained as a nurse. However, when the chances of their father's surviving the cancer became slimmer, and the pain he was going through was growing increasingly intense, Ester's family found it a real challenge agreeing to her sister's view that he should receive an injection of a drug that would ease his pain, put him to sleep, and, eventually, lead to a peaceful death:

> My sister is also direct. Like, you know, she's the type of person that...is tough in whatever she's doing...like you know...Well she...I guess she is of the same level as the nurses. Like she's..."Dad if you want, you know, there is an injection that will just...get it. Like, you know, you'll not gonna feel the pain." Like my Mom was like crying. Like "Why? Are you gonna kill your Dad?" Like you know...like...

Ester's sister had been working in the United States as a nurse for many years and came to Canada for the sole reason of "watching over" (*bantay*) and taking care (*alaga*) of their father during the terminal stage of his illness. The training and experience she had in Western medicine has evidently changed her views about life, death, illness, and pain. Ester found her sister's directness almost comparable with that of the professional nurses in the hospital. Their mother found her sister's option to inject such drug contrary to their cultural beliefs and values. Her sister argued with them:

> Because if he will have to go through a lot of pain, she does not like him to go through such agony. So she said she'd prefer the injection that is...in the States, they give it to patients. They just don't feel it. Like you gonna die like...But here it's not. Here in Canada there is no such thing as that because its kind of like...it is not allowed because it is like killing the patient.
>
> Ya. So you know it can happen. My Mom was so bitter about it because my Mom you know how...how it is with our older folks, "why do you have to do

> that it is not yet God's will." No, but she was just explaining that there is an alternative like in the States because she lives in the States.

Her sister's medical option was definitely unacceptable to the family's traditional as well as to their Christian belief. In extreme situations, cultural difference between the children and the parents, or among siblings, can lead to the person on the opposing side's becoming "not one of us" (*ibang tao*). Ester, in this instance, saw her sister as identifying with the nurses in the hospital instead of identifying with them—her family. Their mother, likewise, saw her sister as adopting values that are contrary to their cultural beliefs and values, and therefore, thinking and possibly acting in an unacceptable way. Disagreement and negative feelings, such as bitterness among family members, can actually dissolve bonds of affinity and consequently bonds of obligation; thus, a family member becomes "not one of us" (*ibang tao*).

From this and the previous example, it is inferred that siblings are expected to support one another throughout their lives, and, even more so, during critical moments in their lives, as in childbirth, illness, or death. This expectation, however, becomes a prime responsibility among Filipinos who migrate to North America because there are not many family members and relatives around to help. The responsibility to care becomes even mandatory if the one who is ill is a parent. Failure on the part of a particular sibling, though strongly censurable, is not as seriously significant as the failure of an offspring.

Summary

Ibang tao is an expression used to refer to "another person" or "other people" who are not members of the family, or to other people who are from other cultures. Filipino-Canadian patients, however, expected and relied on *hindi ibang tao*, which

includes spouses, parents, siblings, and children, to visit, sleep over, and provide care and support when they were in the hospital. More is expected from family members and relatives who are professionally trained as doctors and nurses. These family members and some relatives traveled from neighboring provinces of Canada, the United States, or even the Philippines to welcome a newborn child into the family, to assist in the care of an ill member of the family, or to console each other in times of death. The level of satisfaction of Filipino-Canadian patients concerning the stay of family members and relatives in the hospital depended on the following: the kind of room they had (private or semiprivate) and the type of unit they were in (delivery room, operating room, recovery room, or intensive care unit).

Several significant points were raised concerning who provided care to Filipino-Canadian patients while in hospital. Obviously, Filipino-Canadian patients were taken care of by nurses, doctors, and other health "professionals," who came from either the same or other cultures. Filipino-Canadian patients were very anxious to have family members, relatives, and other "private persons" stay by their bedside when hospitalized. Family members traveled from the neighboring provinces of Canada, from the United States, or all the way from the Philippines when someone is born, critically ill, or has passed away. Kindness, respect, courtesy, approachability, and a willingness to accommodate were important qualities sought by Filipino-Canadian patients from nurses regardless of whether they were from the same or from other cultures. Nurses who were from the same culture and did not have these qualities were considered "not one of us" (*ibang tao*). Most elderly Filipino-Canadian patients have experienced being looked up to as authority figures and are well

respected inside and outside the family; therefore they expect the same regard from nurses whether they come from the same or from other cultures. They also experienced being well looked after by family members when they were sick or handicapped and, therefore, expected to be looked after in a similar fashion by nurses from the same or other cultures. There are more expectations, however, from the nurses who were from the same culture because they were considered "one of us" (*hindi ibang tao*).

Filipino-Canadian patients used the term *kapwa* to indicate recognition or acknowledgement of a shared identity. When used with the prefix *pakikipag*, as in *pakikipagkapwa-tao*, it basically means to have someone share one's identity as a human being. Filipino-Canadian patients used *kapwa* to refer to Filipino nurses who are able to identify with them on the basis of common characteristics traits that make up who they are, such as being kind, respectful, courteous, approachable, and willing to accommodate. It can also be based on common experiences, as in the experience of being an immigrant or of being a patient. It is also through *pakikipagkapwa* that nurses from other cultures become "one of us" (*hindi ibang tao*). Noncompliance to the values of the family can lead to conflict and be interpreted as disloyalty. Disagreement, disloyalty, and other negative feelings, such as bitterness among family members and relatives, may dissolve bonds of affinity and, consequently, bonds of obligation; hence, a person becomes "not one of us" (*ibang tao*).

CHAPTER 5

RESULTS: PART 2

"WATCHING OVER" AND "CARING FOR" (*BANTAY AT ALAGA*)

In this chapter, I will describe further the concepts of "not one of us" (*ibang tao*) and "one of us" (*hindi ibang tao*), and the corresponding tasks of "watching over" (*bantay*) and "caring for" (*alaga*), in the three dimensions of patient care: physiological, psychosocial, and spiritual. After conducting several interviews in Pilipino, I realized that participants used two concepts interchangeably to articulate their experiences as they shifted from English to Pilipino or from Pilipino to English. The two concepts— "to watch over" (*bantay*) and "to care for" (*alaga*)—would not have been evident if I had conducted the interviews only in English. Examination of their experiences revealed that, based on who provided the care, participants made a clear distinction between these two concepts. "Watching over" (*bantay*) was used to refer to the tasks rendered by "one of us" (*hindi ibang tao*), whereas "caring for" (*alaga*) was used to refer to the tasks rendered by "not one of us" (*ibang tao*). Designation and appreciation of these tasks are expressed in a variety of ways: the language of words, the language of gaze, the language of touch, and the language of food. Findings of this study showed that the extent and depth of these expressions in any nurse-patient interactions are determined by the concepts "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*).

"One of Us Watched Over"
(Hindi Ibang Tao ang Nagbatay)

The Filipino-Canadian patients expected their family members, relatives, and other "private" persons who were considered "one of us" (*hindi ibang tao*) to "watch over" (*bantay*) them. "Watching over" meant keeping an eye on and providing "private" and "personal" care. For example, Lito's wife and sister were concerned about who was going to "watch over" Lito if he did not regain consciousness:

> My sister-in-law and me already spoke about... "Who will watch over him? [*Sino ang magbantay sa kanya*]?" I thought he will not recover...I said, "What is this... to put him in a nursing home? My sister-in-law said "to have him stay in Calgary for the meantime." His father can take care of him.

Note that she used the word *magbantay* at the beginning of her statement, but at the end, she shifted to the English words *take care of* to refer to what the father would do. In the Philippine language, *bantay* means literally "to guard," but in this context, it is used to mean "to watch over." There are few instances, however, when the word was used literally. A concrete example was assigning security personnel to guard Lito because he jumped out of bed when he needed to urinate and sometimes wandered on his own, once becoming lost in the hospital.

The roles played by "one of us" (*hindi ibang tao*) in the task of "watching over" (*bantay*) the patients included being at the bedside as a "private" care providers and being there as a "go-betweens." The responsibilities of performing the task of "watching over" were as follows: keeping an eye on the condition of the patients, assisting in their general and direct care, and monitoring their conditions, needs, and treatment. The responsibilities also involved communicating, which included translating, interpreting, and advocating on behalf of the patient. These

responsibilities will be expanded further in the subsequent section and subsections, when the three dimensions of patient care will be discussed.

Henry's experience best exemplifies how the roles of private care providers and go-betweens were played by "one of us" (*hindi ibang tao*)—specifically, his wife, mother, and sister. It also gives a glimpse into how family members and relatives determined who would bear the weight of responsibility in the task of "watching over" (*bantay*). In spite of the fact that Henry's wife had to attend to their son, who was having asthmatic attacks at home, she immediately rushed to her husband's side when his employer phoned to say that he had been taken in an ambulance to the emergency room. It was a challenge for her to be available for both her husband and their son, but as a wife and mother, she had to be available for both of them. Henry was fortunate that his mother and sister, the latter of whom is a nurse, flew from Virginia to help his wife cope with the situation.

It was also noted that his wife had been a practicing physician in the Philippines; otherwise, it would have been difficult for her to decide whether a dangerous drug prescribed by the doctors was the best for him considering the risk involved due to its possible side effects:

> I was asked by some of the doctors [about] that kind of medication that will be given to me which is effective only from the first six hours of the first attack. And they called it [name of the drug] and at that time it was my first time...I didn't know anything about medication so I said, "You better ask my wife." They did and since my wife was a medical doctor back home, she knows about it and she let them do it. And luckily...it was explained by the way...what will be the effect of the drug... say like bruises or anything that maybe going to the brain or something. But we took the chance and I was lucky that the effect was only a bruise...I have bruises all over...[was again in tears...pause].

Because of her knowledge and skills, Henry's wife was able to take the responsibility of making an informed decision at a critical moment in his life and to bear the weight

of responsibility for taking such a risk. Based on this example, one can conclude that the designation and sharing of responsibility among those who were considered "one of us" (*hindi ibang tao*) was determined by the individual's availability, knowledge, training and skills, relationship and closeness to the patient, and position in the hierarchical structure in their family.

"Not One of Us Cared For" (*Ibang Tao ang Nag-alaga*)

"Caring for" (*alaga*) was associated with "professional" care provided by those who were considered "not one of us" (*ibang tao*), such as physicians, nurses, dieticians, laboratory technicians, and other personnel in the hospital. Besides being a "professional" care provider, nurses also played the roles as givers of comfort, health teachers, and advocates. The task of *alaga* included responsibilities such as assessing and diagnosing the condition of the patients; monitoring, reporting on, and recording the condition, needs, and treatment of the patients; providing general and specialized care; and referring the patients to the appropriate services.

Quality of Interaction and Depth of Relationship

The frequency and length of time spent and the amount of attention given to the patients, the urgency of the patients' condition, and their length of stay in the hospital determined the quality of interaction and the depth of relationship developed and, subsequently, the quality of "professional" care provided by the nurses who were considered "not one of us" (*ibang tao*).

Frequency and Length of Nurses' Visits

The frequency and length of nurses' visits depended on whether the patient's condition was life threatening. Florence recalled, for example, the urgency of her condition after the Caesarian section with her second baby:

> I developed DIC and so I had to be rushed from [name of the hospital] to [name of another hospitals] because that's where the hematologists are...When I first came, I was quite serious. So [like] I had actually, at [name of the hospital], two nurses watching me and actually taking all my vital sign and everything. I wasn't aware what was happening because of the condition I was in. It was like...I was bleeding all over...I had to undergo several blood transfusion as well as plasma transfusion. There was a lot going on there and I didn't really have enough time to get to know the nurses but I know they were very very intense in monitoring me. Every now and then every fifteen minutes, I think they got my BP and check everything. Every single, you know, every change in my condition, they would call right away to the doctor.

The amount of attention was underscored by the fact that there were two nurses assigned to "watch" her. Significant is the use of the English word *watching* to indicate how closely her condition was being assessed and monitored. The sense of urgency was expressed in terms of being "rushed" from one hospital to another hospital and calling the doctor "right away," and the amount of time the nurses spent "monitoring her," using descriptors such as "every now and then" or "every 15 minutes." This showed her perception of how seriously the nurses took their responsibility of assessing and monitoring her condition.

Although they were with her most of the time, Florence observed that she really did not have "enough time to get to know the nurses." She contrasted this with her first experience in the hospital:

> There was a lot more free time the first time. Free time for bantering and free time to talk. Whereas the second time, it was more...not a distrust but a lot a greater concern.

Florence repeatedly used the word "time," describing how much "free time" there was the first time "for bantering" and "to talk," which was obviously linked to the nurses' and patients' getting "to know" each other. These responsibilities were similar to those mentioned under the section on "One Of Us Watched Over" (*Hindi Ibang Tao Ang Nagbantay*), except that the tasks involved in assuming the responsibilities of "not one of us" (*ibang tao*) in "caring for" (*alaga*) the patients required special knowledge, training, and skills.

Continuing the discussion of her sense of time and how she related it to the quality of her interaction with the nurses, Florence reiterated that she had no problem with the nurses. In her first hospitalization, she recalled that there were not as many Filipino nurses as there were Caucasian nurses, but a Black nurse in particular stood out in her memory as being "very nice" to her. She perceived the Black nurse as being able to sympathize and empathize with her because she, too, was from another culture. She also described Caucasian nurses as being "nice and helpful," but she missed the kind of relationship she had established with the nurses the first time she was hospitalized. She realized that the longer stay in the hospital gave her and the nurses the opportunity to get to know one another better.

In addition, Florence alluded to the frequency and the length of time the nurses stayed to talk with her when I asked her the question, "In what sense did you find the Black nurse and the other Caucasian nurses very nice?"

> Well, I guess when I say nice...[it] is when she stays around and she talks to me [laughing]. Sometimes what's nice is...well, the Caucasian nurses oh they hang around too, to talk with you too and shared family stories and stuff also; but she ...this other nurse like she [referring to the Black nurse] kind of wanted to talk a little bit more than the usual, you know. Although I feel some of the nurses were telling stories but they sound more professional like OK they're telling stories while they're doing the work but sometimes like

> some of the Filipino nurses I met, they kind of hang around [laughing]. They only leave when somebody buzzes them [laughing]. Yeah so yeah.

She also found that talking about the family and other personal topics made her feel at ease, but there was something more to what she called "hanging around to talk." This was reiterated by Anita's response to the question, "If you have a chance to talk with the nurses who took care of you, what would you tell them?"

> [Laughing] Perhaps ah...specially with the first one because I was not feeling well with the first ...with the first hospitalization *ne*...I will tell them what I really felt...*ne*...that I felt so weak...that I felt I'm going to die like that because that was really what I felt that I'm going to die [laughing]. Ya.

Anita described herself as not being open and preferring to keep her feelings to herself. Although she realized the importance of openly expressing her feelings and needs to the nurses, she still insisted on telling them only after she had gone through the experience. Besides talking about family and other personal things, Anita had other suggestions when asked, "What would you recommend the nurses to do in the future to encourage you to open up?"

> Oh [laughing] no, perhaps...they...they always ask every...actually they always ask how do you feel but I always said good but even though I am not feeling good ne. Perhaps, I don't know [laughing] perhaps just tell them that even though they are saying...the patient will say I feel fine even if it is not true. Perhaps they can encourage the patient to open up ne. Something like the pain...people are not easily to open to other people even if they are nurses who are taking care of them, isn't it?
>
> I think if you talk [of] about similar...similar topics...what you call that? Let's say you...you have conversation about family, for example, like that what else or perhaps about children if you have children or about interesting topics that might interest them...interest the patient too, isn't it?

She also observed how busy the nurses were in the hospital. The nurses did not have the time to "hang around," or, in other words, they did not have the time to stay and talk with the patients. This indicates how Filipino-Canadian patients

appreciate when nurses take the time to make them feel comfortable and take an interest in getting to know them.

Length of Stay in the Hospital

The Filipino-Canadian patients attributed length of stay in the hospital as a major factor in the depth of interpersonal relationship they had with nurses. The experiences described by Florence and Karen and their interaction with Black nurses revealed a connection between the length of time patients stayed in the hospital and the depth of relationship they established with the nurses. The extended period of time Florence stayed in the obstetric and gynecology ward had given her and the nurses the opportunity to get to know each other better. This observation was contrary to Karen's experience with the Black nurse who mistook her for another patient. Apparently, Karen was newly admitted to the geriatric ward shortly before the unpleasant incident. It was strange to find the chart of another patient still hanging on the wall. Patients' charts usually go wherever patients go, and the head nurse should have been aware of any new admission or transfer to her ward. Although this might have been a classic example of mistaken identity, Karen perceived that she was discriminated against and felt bad about how she was treated.

Urgency of the Patient's Condition

The depth of nurse-patient relationship was not fostered only by the frequency and amount of time spent with the patients, length of stay in the hospital, the amount of attention given to the patients, and the quality of interaction, but was also determined by the urgency of the patient's condition. In our previous example,

Florence did an excellent job of describing the impact her condition had on her hospital experiences:

> And when they decided to move me to [name of the hospital], at that time, I think I was on my way to recovery from the DIC because the blood coming out wasn't as fresh as the [one] previous day. But even then, when I went there, I had attention of one nurse assigned to me just to watch me. And again, in a way, because of the...you know, complexity—the seriousness of my situation they had to assign one person who had like 100% attention on me.

The doctors explained that continuous bleeding would shut down all her body mechanisms. There was nothing else they could do but to replace the blood she had already lost, and her chance of survival was dependent on how her body recovered after a blood transfusion. Florence was well aware that her situation was different, because her chances for survival was fifty-fifty, but she more or less knew when her condition was no longer serious:

> The funny thing is I knew that I wasn't serious anymore when OK first of all, they moved me to a regular room. It was hockey season that time. It was the finals for Edmonton Oilers. I think I needed something and I kept on buzzing, buzzing, buzzing and nobody...I figured out I think I had a TV on. "Oh, I guess it's the hockey, right." So I buzz, nobody is coming. I buzz... probably, they don't think I am serious enough to care. No? So... and then right after the game ended, here's these two nurses coming, "you called" "yeah but you weren't coming" "Oh because it is so exciting."

Florence found the situation funny and understood how involved Canadians are with hockey. She discerned that the nurses had congregated in the lounge around the television to watch the hockey game because she heard them:

> I said that's good news because if it's so hard, you know, if I were serious they would come right away [laughing] so that was my basis [laughing] whether I was serious or not [laughing].

Florence noticed, from the first day she was transferred to the hospital, how closely the nurses monitored her condition. She remembered that they were right next to her watching every single twitch and listening to every single groan she made when her condition was serious. Florence perceived that the seriousness of her condition

brought the nurses to her side at once, and when she did not get an immediate response to her call, she sensed that her condition had improved to the extent that the nurses did not deem it necessary to come right away. In other words, nurses were aware that the critical moment was over, and they were no longer anticipating anything worse. The insight Florence had of her condition and the care she received from the nurses over time made her more tolerant and less demanding. She realized how devoted they were when her condition was life threatening.

In conclusion, the frequency and length of time spent and the amount of attention given to the patients, the seriousness of the patients' condition, and their length of stay in the hospital determined the quality of interaction and the depth of relationship established between the nurse and the patient and, subsequently, the quality of "professional" care provided by the nurses who were considered "not one of us" (*ibang tao*).

Three Dimensions in Patient Care

Excerpts of the experiences of Filipino-Canadian patients concerning hospitalization helped to identify and define who did the "watching over" (*bantay*) and who did the "caring for" (*alaga*), and the conditions under which these two concepts were used in the physiological, psychosocial, and spiritual dimensions of patient care. There were situations when it was difficult to draw a line between the roles and responsibilities of "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) in the tasks of "watching over" (*bantay*) and "caring for" (*alaga*). However, Filipino-Canadian patients had a distinct way of using them as they described their experiences in the hospital. The roles they played and the successes or failures in

carrying out the corresponding responsibilities by various people involved are presented in the succeeding subsections according to the three dimensions in the care of the Filipino-Canadian patients: physiological, psychosocial, and spiritual. Each subsection is further subdivided into two categories: (a) "private" and "personal" care and (b) "professional" and "specialized" care.

Physiological Dimensions

"Private" and "Personal" Care

Findings of this study showed that "one of us" (*hindi ibang tao*) "watched over" (*bantay*) physiological dimensions of the patient in tasks that were identified as "private" and "personal." Most Filipino-Canadian patients relied on "one of us"—family members and/or relatives—to perform directly tasks that were for them "private" and "personal." To ensure that Anita and I meant the same thing when we used the word "to care for," I asked her whether she felt well taken care of. Her answer revealed that besides the fact that there were certain tasks she would rather do privately, she also considered them personal:

> But... of course doing personal things such as going to the washroom, I do it myself. I have to do it...I didn't ask for their (nurses') help.
>
> Q: You were able to go to the washroom even if you were in pain when walking or standing up?
>
> Yeah, but in the beginning with our first child... my husband helped me with the shower.

Going to the washroom and having a shower were tasks most Filipino-Canadian patients identified as being personal, and, therefore, they preferred to do them privately, either on their own or with the help of "one of us" (*hindi ibang tao*). Anita further explained that she did not expect the nurses to feed her because she could feed herself. She did not expect them to help her in going to the bathroom because she

could do it herself. Although she was aware that patients might call the nurses for help when they were unable to do things by themselves, she reiterated that going to the washroom was private for her. Therefore, even though she found it difficult to do them alone, she would force herself to do what she had to do privately.

Like Anita, Lito said he would force himself to go to the washroom even if he found himself falling. He said that he did not like to use the urinals because he found it difficult to do so. His wife, Laura, recalled that on several occasions, they had to restrain him in the bed because, whenever he felt the need to urinate, he jumped out of bed. Laura attested to the fact that he never used the buzzer to call for help. Laura had to offer something to the Filipino staff, whom she considered "one of us" (*hindi ibang tao*), to "watch over" (*bantay*) him during the night because he never said anything when he felt like urinating.

Monitoring. Although monitoring was one of the responsibilities apparently assumed by both "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*), Laura observed that the nature of the wards in the hospital determined how closely the patients were monitored. In the context, for example, of the Intensive Care Unit (ICU), the word *bantay* was used in two ways:

> Those in ICU are mostly Whites but they are also...because they [patients] are guarded [*bantay*]. When he was not in ICU, there were really many nurses outside [meaning other wards], I could not leave. Yes, he was monitored. Every move I suppose because I was there almost 24 hours. Even (name of the cousin), his cousin, she was my reliever when I have to work. She was there since she does not work. She would watch over [*bantay*] him because the IV sometimes created a sound when it was dislodged or when it was consumed already? [coughing]

Laura used the word "guarded," which is translated in Pilipino as bantay, in reference to what the ICU nurses were doing in closely monitoring Lito's condition.

However, Laura also used the word "watch over," with the same translation, *bantay,* to describe what the family members and relatives were expected to do. Whether she meant and used the words "guarded" and "watched over" interchangeably in the Pilipino language was not very clear. Nevertheless, the example above clearly shows that "watching over" (*bantay*) the patient was a task that family members and relatives, who were closest to the patient (i.e., spouses, siblings, parents, and children), had to do while patients were in the hospital.

Except in the ICU, where all the vital signs of the patients were closely monitored, the role of "one of us" (*hindi ibang tao*) in "watching over" (*bantay*) also included monitoring the needs and the condition of the patients, and the treatments given to them, such as intravenous fluids, blood transfusions, and oxygen.

"Watching over" (*bantay*) was associated, therefore, with keeping an eye on the patient and doing the tasks that are particularly considered "personal" and "private." The word *bantay*, however, was also used to refer to how the ICU nurses closely monitored the patients. "Watching over" (*bantay*) seems labor intensive and demanded more time and attention from whoever was designated to perform such task. Those who were designated with the responsibility of "watching over" (*bantay*) the patients had to meet certain criteria, such as affinity and availability.

From the previous examples, it is evident that Filipino-Canadian patients preferred "one of us" (*hindi ibang tao*), whom they refer to as "private" persons, to assist them with personal tasks. Anita, for example, stressed that she would prefer to have her husband assist her in going to the washroom or taking a shower rather than

calling the nurses. Henry rarely found the need to call the nurses because of the presence of his wife, mother, and sister in the hospital:

> Well when I need something I have to call them [the nurses] in a nice way but I have to ring the bell but it is very seldom that I need something from them because like most of the time my wife was there...my mother came from Virginia OK and my sister arrived here too.

In addition to close affinity with the patient, availability was another criterion families considered in determining who would be responsible to "watch over" (*bantay*) the patient. Henry's wife, mother, and sister took turns in watching over and caring for him in the hospital and his son at home. Lito's cousin, for example, relieved his wife when she had to work.

Genital care. In terms of the care related to the physiological dimension, it was also noted that there was something peculiar about how both male and female Filipino-Canadian patients felt about who did the tasks or procedures that had to do with their "private parts." During her interview, for example, Brenda was very embarrassed when she spoke about private parts while she recounted her experiences in the delivery room and her observations about her father's hospitalization. She indicated that "in the Philippines, we are very private when it comes to the genital parts, and therefore we do not like 'other people' (*ibang tao*) to do those tasks." The tasks, therefore, of "watching over" (*bantay*) the physiological dimension of the patients included those considered "private" and "personal," such as washing the genital parts and the anus, bathing, and changing underwear or clothing.

Evidently, speaking about private parts was embarrassing (*nakakahiya*), and it was more so for patients whose private parts had to be exposed to "other people" (*ibang tao*). Brenda emphasized the fact that her mother stayed at the hospital all the

time to do these tasks for her father because he was embarrassed (*nahihiya*) if "not one of us" (*ibang tao*) performed them. Laura felt the same way when she had her first baby. She was uncomfortable and self-conscious when a medical student whom she considered "not one of us" (*ibang tao*) monitored her progress while she was in labor:

> Oh my God, he was always looking because you were like this *eh* [demonstrating how her legs were spread]. You can not hide because the light was focused right there and the rest of the room was dark. My God! Maybe they said, Oh! The *ano* [expression meaning "that thing"] of this woman is so big [laughing] Oh....

Note the euphemism when Laura tried to refer to her genitals as *ano* ("that which is being referred to" or "what-you-may-call-the-thing"). Using euphemisms was a common tendency of most Filipino-Canadian patients when they felt embarrassed speaking about their private parts or anything to do with them. They actually used words or phrases that were less expressive or direct but considered less distasteful, offensive, or vulgar. Brenda, for instance, recalled being asked to lie on her back with her legs spread out to make her "private parts" (genitalia) exposed to those who were "not one of us" (*ibang tao*), such as the delivery nurses and doctors. She explained that people in Canada do not mind this sort of thing as much as Filipino-Canadians do:

> Here, it really doesn't matter anymore...but for us Filipinos, it is so *nakakahiya* [embarrassing] when the private parts are exposed...[laughing]. They were... looking at me, so I told the doctors, "You just go away, stay outside" [laughing].

In numerous instances, *hiya* was alluded to in relation to the genital parts being exposed. Most Filipino-Canadian patients used the word *hiya* in the same way that Carla and Victor did, denoting shyness, embarrassment, and timidity. In this situation,

however, it implied more a feeling of uneasiness associated with "private" parts being exposed or seen by other people, particularly those who are considered "not one of us" (*ibang tao*). Although *hiya* was also used in several instances to mean "ashamed of" in the succeeding examples, it was used more appropriately to denote a sense of propriety.

In addition to being uncomfortable and embarrassed, Laura also felt relieved that Lito (her husband) was not with her in the delivery room—otherwise she might not have been able to push, because of the way he teased her about seeing her "private parts." She also explained that Lito chose not to be in the delivery room because she anticipated that he would be the first one to faint.

Male and female Filipino-Canadian patients reacted similarly to having "not one of us" (*ibang tao*) assist them with private and personal tasks. When Lito regained consciousness after a heart attack, his wife observed that he never called or asked the nurses for assistance. Lito said, "No, I didn't. That's one thing, I never do. I don't call nurses." When asked why, he said he did not know—but later, he explained that the urine or stool would not come out if there was someone around regardless of whether it was a male or a female nurse. His wife assumed that most Filipino men felt the same way. She said they do not like to be treated in that way, yet Lito said that it really did not matter to him. However, Laura recalled that, according to him, he did not like his genitals ("private parts") to be exposed. Lito argued that seeing male "private parts" no longer bothered the nurses, but Laura thought that it still bothered him. Again, the same issue of exposing body parts was raised, and, like Anita, Lito

reiterated that he would force himself to do what he needed to do privately by himself:

> I don't have that [referring to the feeling of being intimidated]. It is just that I do not like to...I know that they are busy. So as much as possible, if I can, I myself will go to the...
>
> Q: *Eh* if you can not manage by your self, how will that be?
>
> That's it. *Bahala na* [an expression that is common among Filipinos meaning "whatever will be will be"] *basta* [so long as]...because it is painful also. The catheter...is painful...a catheter was tried...it was painful really painful.

He resorted to saying, "*bahala na*," which can be interpreted as being resigned, but he added a conditional word, *basta*, meaning "so long as" it was not painful. He recalled, and repeatedly said, that the use of a catheter was indeed painful. His wife did not realize how painful catheters were because she never had been catheterized, so he stressed how painful this procedure is for men.

In the absence of family members and relatives, Lito's wife relied on the health "professionals" from the same culture, whom Laura considered as "one of us" (*hindi ibang tao*), to keep her updated regarding his condition. One Filipino orderly, for example, informed her that the nurses were worried because there was blood in his urine. The Filipino nurses were also the ones who told Laura that her husband had gotten lost. A security guard was eventually assigned at night to keep an eye on him. It was evident that Laura relied on the "professional" nurses and other health "professionals" from other cultures, who were "not one of us" to "care for" (*alaga*) Lito. Laura, however, also expected the Filipino nurses or other hospital staff to "watch over" (*bantay*) him, which included informing and updating her of Lito's condition, needs, and treatment, because, coming from the same culture, she considered them "one of us" (*hindi ibang tao*).

Informing and updating the family members and relatives will be explained further in the subsection "Communication" under the section on the "Psychosocial Dimensions." *Hiya* is another topic that will be explored more extensively later, in the subsection on the "Psychosocial Dimension," as it seemed to play an important part in how Filipino patients interacted with the "private" and the "professional" care providers. In the following subsection, the "professional" care as related to the physiological dimension is described as perceived by Filipino-Canadian patients.

"Professional" and "Specialized" Care

Filipino-Canadian patients perceived that in the task of "caring for" (*alaga*), some of the responsibilities of "not one of us" (*ibang tao*) in their role as "professional" care providers included assessing and diagnosing the patients' condition, providing general and specialized care, and monitoring their conditions, needs, and treatments. They also assumed the responsibilities of reporting, recording, and referring patients to the appropriate services.

Filipino-Canadian patients distinguished the "professional" care given by Caucasian nurses from the "personalized" care they associated with Filipino nurses. Although she noted that some Caucasian nurses also stayed for an extended period of time, as the Filipino nurses did, being "professional" meant that the nurses strictly adhered to the time needed to give nursing care to their patients. The terms "personalized" and "professionalized" in describing the nursing care in this context were used as an approach or as an attribute associated to the nurses who gave the care, and the terms "personal" and "professional" were used as descriptors of the nature of the tasks the nurses performed for the patients.

Some of these tasks were classified as specialized care. This specialized care was distinguished from the general care viewed earlier as being routinely rendered to all patients regardless of their condition, such as tasks that had to do with grooming, hygiene, and comfort. These specialized tasks required special knowledge and skills training. Although monitoring was among the responsibilities assumed by nurses and the doctors, particularly in the intensive care unit (ICU), the care given to the ICU patients was classified as specialized care because of the seriousness of the patients' conditions.

Assessing and diagnosing. Assessing and diagnosing patients' conditions were responsibilities that had always been associated with the health professionals, particularly nurses, physicians, and medical interns. Ignacio, for example, who was hospitalized twice for pancreatitis, thought that it was an emergency room nurse or a medical intern who examined him and asked him persistently the same question:

> I think it was the emergency room nurse...no it was...I think he was an intern. I don't know what it was...he kept asking, "How many things did you have?" I said, "I have...the only thing I had was two big servings of lemon pie. That's all I had." Because he was saying that this type of problem is precipitated by alcohol, so he kept on saying, "are you sure you did not take?" And I said, "No." And I was doubled up in pain. And I said, "I am positive I did not take any..." That was the only thing that I remember. He was persistent in asking the same question whether I took alcohol or not. All he has to do to confirm is to smell my breath. I kept telling...because he was telling me that the usual precipitator for this problem is alcohol.

Most Filipino-Canadian patients became annoyed when nurses and other health professionals took a long time and asked either too many questions or the same one repeatedly, to find the truth or to further probe the situation. Henry expressed his impatience when one of the emergency team in the ambulance was probing him with too many questions while he was suffering a heart attack:

> Before this ambulance guy took me, they asked me a lot a questions. Probably just to find out if I am conscious or not or if I know what they are asking me or something like that. My age, my name, what was I doing at that time, or where is the pain? All of those kinds of questions. So finally I [was] kind of sick and tired of those kind of answering those questions so what I did, "please take me to the hospital." They did after all. I was still joking with the nurses and everything here and never thought of any danger to my life...never...never came even in my mind that this might be the end of my life...something like that.

In both instances, Ignacio and Henry could not tolerate the questioning because of the pain or discomfort they were suffering. The Filipino-Canadian patients were anxious for an immediate relief, whereas the nurses and other health professional were conscious of their responsibility to thoroughly assess the condition of the patient and to come up with the right diagnosis.

Monitoring, recording, and reporting. Filipino-Canadian patients perceived the regular rounds as important parts of the nurses' task of "caring for," which included checking the vital signs, such as breathing; pulse; heartbeat; blood pressure; temperature; and signs of swelling, pain, discoloration, and discharges. Besides checking the patients' comfort and ability to sleep, defecate, and urinate, they also made sure that oxygen, intravenous fluids, and blood transfusions were administered. All these were tasks identified and defined as professional care that nurses who were "not one of us" (*ibang tao*) did on a regular basis in the morning when the patients woke up and in the evening before they went to sleep. These tasks were part of their responsibility of continually monitoring, recording, and reporting the patients' condition, needs, and treatment.

Willie also mentioned how fortunate he was that a nurse was making her rounds when he accidentally felt weak and lost consciousness after pulling a chair in

front of the television. The worst would have happened had the nurse not seen Willie lying on his bed with his face down, hardly able to breathe.

> She [nurse] was calling the...[blue team] describing to them what she observed in me until she said eh we need to have...I could hear her say, my cardiologist is needed and then she said, I will be transported to the operating room. And then at that time nothing more...I faded away already [hands motioning to his face and forehead].

Providing general care. Another responsibility identified by the Filipino-Canadian patients as professional care was assisting in their "general" care. General care implied many things, from merely lifting a body part to actually supporting them while they sat, stood, or walked. It also included grooming and hygienic tasks, such as brushing the teeth, combing the hair, shaving the beard or mustache, washing, bathing or giving a shower, and taking them to the washroom. Willie, who was hospitalized for pneumonia, recalled how two nurses answered his call for help immediately when he realized that he could not stand:

> I was very weak that I had a wheel chair. Whenever it is possible and if I can make it, I go on my own. I went to the washroom. I have finished what I need to do. I was already standing...then I was about to go to wash my hands in the lavatory...there is a chair there and I sat there from the wheel chair. I transferred to the chair, which was more like a stool. Then I finished washing my hands. I was just about to stand, to go to the wheel chair [but] I couldn't do it. I was forced to call for a nurse. There is an emergency button in the washroom, isn't it? In a few minutes, there were two of them and asked me, "why?" I said, "I could not stand." They helped me stand and then supported me until I reached the bed. Uhm and then they looked what else was wrong with me.

Although other patients considered bathing private and personal, they also associated it with professional care, but under the category of general care if done by nurses in the hospital. Willie, for example, had difficulty bathing on his own but was eventually forced to give himself a bath when he was discharged. He told the doctor about this difficulty in providing for and maintaining his hygiene and therefore requested extended home care. Nurses were expected to intervene only whenever

patients could not do things by themselves. Anita, who was described in the previous chapter as having had two Caesarian sections, remembered not being able to lift her back from the bed, clean the surgical site, or change the dressing and her sanitary napkins. Lifting her back from the bed and changing sanitary napkins were general in nature, but cleaning the surgical site and changing the dressings were the kinds of professional care that were more "specialized" because they required special knowledge, training, and skills. Nevertheless, these were the kinds of tasks patients expected the nurses to do, especially when they were not able to do them by themselves.

Providing specialized care. Checking the blood pressure, administering medication, changing dressings, and preparing for laboratory tests and surgical procedures were also identified as "specialized" care that the nurses did for the patients during their stay in the hospital. Willie described how the nurses and other health professionals closely monitored his condition and treatment while he was in the ICU:

> There was a doctor who never left my side and there was a nurse too but the doctor never left me. He kept asking what was painful and particularly asked if my chest was painful. No, the only thing they wanted to know was what was painful. I said I felt weak and then that...they said if there was any pain ahh in my chest any chest pain I have to tell them. If there is anything I feel and then I said, "There is pain until here [pointing to his upper abdomen]." There were all sorts of medicines that they... uhm until there were more and more of them came. There was someone who came who seemed to hold the highest position that the doctor who...and every morning there is a doctor who goes around.

Willie observed the difference between the specialized care he received from the nurses and other health professionals in the intensive care unit and the general care he received routinely in other units. He also noted the high position held by one of the doctors who joined the rounds every morning. Professional care was, therefore,

synonymous with specialized care, because knowledge, training, and skills were required in carrying out the responsibilities involved. The competence that nurses and other health professionals exude made Willie confident that the care he received was professional.

Ignacio also recounted his experience when a nurse from another culture removed his staples:

> I had staples...the nurse that took it off was from...she is "Bombay" [a general term used to address those who come from East India]. But at first, I was worried that this ugly looking staples she had to use a special tool...I had nine of them but I was [laughing] since that is...my first surgery they had the regular suture. There were only four or five I think so there was no problem but this one they had clips. I was a little scared but she...she assured me "Don't worry, it just stings...very small sting and that's it." And really the first two or three yes there was the sting but after that it was...pretty much routine. I was there I was a little *takutin* [translated as "fearful"] [laughing].

Ignacio described how he was a bit frightened, but the nurse who removed the staples assured him that except for a small sting, there was nothing to be afraid of. This example illustrated the two important roles played by nurses in the hospital. The nurse acted first as a professional care provider, by cleaning and dressing his surgical wound and removing the staples, and second as a "giver of comfort," by assuring him not to worry and informing him what to expect in the process.

Ignacio likewise recalled how well the nurses as professional care providers "cared for" (*alaga*) him by closely monitoring his medication:

> I had pretty good care because I didn't have to ask for my medication. There was even a time like they were giving me pain killers by the end of the second day I said, "I don't need it anymore" the nurse said yes but the doctor's order said you have to take it so I took it. So I got a pretty good care.

This showed how conscientious nurses were in playing their role as professional care providers and assuming the responsibilities of monitoring and administering the patients' medication.

Another example of professional care identified was the pre- and postoperative care. Ignacio remembered how the nurse from another culture insisted that he take his shower the night before the operation and described how a male nurse from the same culture monitored his condition by checking his vital signs after his operation:

> The male nurse that looked after me was a Filipino. I remember now that I was suppose to within so many hours after surgery...I was suppose to be able to...to pass water but I couldn't. I think it was the aftereffect of the anesthesia or something. I just couldn't as hard as I tried I couldn't and the male nurse said, "OK OK then we have to use the catheter." I kept saying..."Oh...I think I can do it...I think I can do it." Two hours later I still couldn't do it. So I said, "OKOK" and that was...the delay was my...fault not his. I was trying to see [it] if I could do it on my own but like he was saying that is the after effects of the anesthesia that sometimes although it feels like you have the control but really it is not there. But I...I was a little *matigas ang ulo* ["hardheaded" or "stubborn"] so [laughing].

A catheter was ordered immediately following his operation. Ignacio refused the procedure, hoping that he could pass urine without it. He described his response as being "hardheaded" or "stubborn" (*matigas ang ulo*) despite the explanation given by the nurse that his loss of bladder control was a temporary effect of anesthesia. He stressed the fact that the delay in inserting a catheter was at his request and not the nurse's fault. Ignacio, however, remembered another incident when the nurse failed to discontinue his intravenous fluids at the time prescribed by the doctor:

> Oh, there was one incident the previous time that I was there for my pancreatitis. I was on IV for almost a week already and I was there and the day came that I was OK...your IV was going out. [And] oh, my IV was suppose to be taken early in the afternoon and I didn't get it taken until after supper. I didn't blame the nurses.

The delay in discontinuing his intravenous fluids upset Ignacio, but he perceived that it was not entirely the fault of the nurses:

> Although I felt upset about taking a long time, I really didn't [blame] them. I pitied them because she was really practically running back and forth doing too many things. I remember now, that was one of the reasons why they went on strike because the staff had too many things to do that some of the things they were required to do could be delegated to a nurse aid or something like that. So...well any way that was the only incident that I remember now when I had my surgery. I had pretty good care there.

He saw how overloaded the two nurses were that day and remembered that understaffing was one of the reasons for the nurses' strike. In this situation, he did not blame the nurses but instead pitied them. He also described how he struggled to keep the needle for his intravenous fluid in place:

> My only other problem was the IV...they could unplug it...my other complaint was that...the tape they used to hold the thing down wasn't long enough... [laughing] so that by two hours or three hours later it starts to get undone so I was telling the nurse, "Why not put a longer one and then put it all around so that way it will last all the way until tomorrow?" And she said, "No, we don't want to restrict your circulation there. I can't have the tape go all the way around." So I was trying to tell her, "You don't need to put it on tight just make sure that the tape overlap each other because that way it will stay longer whereas if it is the one on the skin the end of the tape starts to undo...and so I was trying to tell...just let them be long enough so that they overlap." And she said, "No, I can't." She said, "it might restrict the circulation in your arm." So I did not persist anymore.

He did not insist that the nurse put tape around his wrist but instead tried on his own to use a piece of cloth to make sure the needle did not become dislodged when he was asleep. When asked what he would say to the nurse or nurses who took care of him if he had the chance to talk to them again, he said,

> First of all, I'd like to apologize to that nurse. Before their strike, she was really...at that time, I was trying to be like an impatient spoiled brat. But really at that time, I wasn't aware of it but I did notice that they were only two of them that night and she was really busy doing all the things that was required for her to do. I would like to...I would have liked to apologize to her. Although I wasn't cross to her but still I wasn't a...I was with a long face [*nakasimangot*] [laughing]. I would have liked to apologize to her that I do understand at that time that it was not her fault...that the delay in taking off my IV was just simply because they were under staff. I will say to her, "I am

> sorry if I was a little difficult..." but they are only doing their job. I really can't...If I really have to think...they are just doing their job.

Ignacio wanted to apologize because he realized in retrospect that he was unreasonably impatient and that the delay had several causes. First, the hospital was understaffed. Second, the nurses were busy and overworked. He also realized that the nurses were doing the best they could to fulfill their roles and to assume their responsibilities.

In summary, Filipino-Canadian patients expect "one of us" (*hindi ibang tao*) to assist them in performing their personal care privately and "not one of us" (*ibang tao*) to provide them with the professional and specialized care. Some of the responsibilities of "not one of us" (*ibang tao*) in the task of "caring for" (*alaga*) included assessing and diagnosing the patients' condition, providing general and specialized care, and monitoring their conditions, needs, and treatments. They also assumed the responsibilities of reporting, recording, and referring patients to the appropriate services. Findings show that family members and relatives play the roles of personal care providers and go-betweens, whereas nurses assume the roles as professional care providers and givers of comfort.

Psychosocial Dimensions

Besides being particular about who provided care to them while in the hospital, Filipino-Canadian patients were also anxious about how they interacted with those who were "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*). Excerpts from their stories showed explicitly and implicitly how crucial communication was in maintaining their psychosocial wellness. The degree of openness and disclosure in communicating, and the depth of interaction in

establishing their relationships, depended on whether the Filipino-Canadian patients considered the individuals "one of us" (*hindi ibang tao*) or "not one of us" (*ibang tao*). This was clearly manifested in varying dimensions, from the almost impersonal to the most personal, from the superficial to the deepest and most personal.

As I stated earlier, it was evident that Filipino-Canadian patients expressed themselves in their stories in various ways—the languages of words, gaze, touch, and food. I will present findings relevant to the psychosocial dimension accorded these four ways of communicating with those who "watched over" (*bantay*) and "cared for" (*alaga*) the patients. Besides these two categories, the criteria mentioned earlier in determining the responsibilities and the weight of responsibilities also applied in determining who interacts with the patient, the kind of interaction, and how they established relationships with those considered "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*). These criteria included the family members' and relatives' position in the hierarchical structure of the family; their relationship and closeness to the patient; and their availability, knowledge, and skills.

Communication

Most Filipino-Canadian patients referred to "pressing the button" as one form of communication in the hospital. Anita, for example, acknowledged that all she had to do was to push the button and the nurses and/or the nurse aides came. "Their care is very good. Actually, every time you call them they are always there." When asked whether they understood exactly what she needed, she expressed that there were things she would rather not tell them:

> Yeah [laughing] but I didn't tell them that I cried in the beginning. I didn't mention. No, but to my husband yeah. He was not there. I cried during the night and I just told him when we were at home already not in the hospital.

> No one in the hospital...knew...laughing...[I was in] distress...no...They never knew. I didn't tell anybody.

Many Filipino-Canadian patients have great difficulty articulating their feelings. Anita, for instance, described her personality as not being open and realized that openness was essential in the process of communicating with the nurses how she felt if she was to receive good nursing care. Although she felt no need to tell anyone about her feelings, Anita acknowledged disclosing her feelings to her husband after some time and preferred telling the nurses only after she had experienced them or the whole incident was over and she was no longer overwhelmed by the emotion. It was also noted that her husband and the nurses were non-Filipinos, but Anita was able to express her feelings more openly with her husband because of his intimate relationship with her. It is still not clear why she could not tell anyone what she felt at the time, but she realized in retrospect the great importance of telling the nurses her exact feelings at the time she had them.

However, Anita felt that it was more important for her to keep her distress private. When asked, "How come you did not tell the nurses?" Anita cited three reasons for not telling the nurses she was in distress. First, she thought that not being open was part of her character; second, she did not feel the need to tell anybody that she cried; and third, she felt that to tell somebody that she cried was a sign of weakness. She expressed the last point emphatically by stressing that what she actually meant was that crying was a sign of weakness (*kahinaan*) and that in reality she was really strong (*malakas*). Was this really the reason why it was important for her to keep her feelings (such as distress) to herself? In the Philippine culture, keeping feelings and emotions to oneself implies "strength of character" (*lakas nang*

loob). The very term *loob* in the Pilipino language signifies that it is something from within and kept within the person. It can also mean "will" or "inner volition."

Four salient points were evident in this situation. First, Anita felt that her husband was "one of us" (*hindi ibang tao*), whereas the nurses were "not one of us" (*ibang tao*). Second, Anita felt more comfortable expressing her feelings—to either *hindi ibang tao* or *ibang tao*—when the incident was over. Third, she used the word *weakness* in two ways. The former instance referred to "weakness of character" (*mahina ang loob*) and the latter to the weakness of the body (*mahina ang katawan*). She believed that keeping her feelings to herself indicated a "strength of character" (*lakas nang loob*) and bravery in times of adversity. In addition, it was important for her that others perceive her as strong (*makalas ang loob*). Anita also linked her distress to her pregnancy.

Anita pointed out that when the nurses asked how she felt, she always concealed how she truly felt. She also cited as an example how hard it was for some people to "open to other people." The use of the words "other people" (*ibang tao*) and the reference to the "nurses who are taking care of them [the patients]" are particularly significant. They show how she subconsciously brought forth the "one of us" and "not one of us" categories and how they applied to nurse-patient interaction. She also suggested that talking about topics of common interest to the patients and the nurses might encourage patients to be more open. The examples she gave of interesting topics to put patients at ease were those concerning their families and children. Filipino-Canadian patients, however, perceived nurses as being "too busy" to initiate conversations of that sort, and she reiterated that the real problem was the

fact that she really did not want to talk. Anita cited two approaches she usually took in handling her feelings or emotions. One was to keep them to herself; the other was to cover them up by saying the opposite of what she truly felt.

Other Filipino-Canadian patients were also asked how they communicated their needs to the nurses. They were asked whether they were able to express their feelings and emotions to the nurses, or whether they found them too busy. Brenda spoke of the buzzers in every room, which patients could use to call the nurses. She said that they came and asked her what she needed. She also recalled that the nurses who took care of her father were very compassionate, and she observed that they took the time to talk with the patients. Taking the time to talk to the patient evidently was meaningful to Filipino-Canadian patients and their families. It was important for them to see that the nurses were not always in a hurry. The nurses, therefore, had to be aware of not only the amount but also the quality of time they spend with their patients. If the patients were willing to open up and were able to express themselves to the nurses, there was no reason why the nurses would not spend time with them. On the other hand, if the patients were not honest enough to tell the nurses what they truly felt, then the nurses had no reason to think otherwise.

Victor attributed his difficulty in "opening up" to his being shy. He described himself as sometimes shy, especially in public. He observed the difference in himself when he came to Canada. He acknowledged how animated he used to be in the Philippines and how intimidated and shy he had become here in Canada. He had no idea if he would ever overcome his shyness. Nevertheless, he felt that he was somehow able to cope and had adapted himself to Canada. When asked what advice

he would give to other Filipinos who are hospitalized, he advised that the key was to "be yourself." He realized how hard it was to associate with other people, even friends, because he was shy:

> Simply "be yourself" if *ano* [that which is being referred to]...wherever you go be yourself. That is hard here [Canada] once you are shy [*mahiyain*] with people. It is hard to associate [*makihalubilo*] with others. Yeah, eh sometimes here [Canada] I am still shy [*nahihiya*] with friends.

He realized how shy he was with people in general and how hard it was to associate with "others" (*ibang tao*) in particular. He found himself shy even with friends. He wondered if that was perhaps how he was—quiet and shy when dealing with people. Victor also wondered whether shyness was a characteristic one could easily overcome. He tried to overcome it by listening to conversations but seemed to accept the way he is—quiet and shy—although other people interpret his being "quiet and shy" as being kind. He jokingly said that he is kind when asleep.

Ester suggested that Filipino-Canadians should communicate with the nurses directly:

> I probably will tell them [Filipino-Canadian patients] to ask whatever they need, you know, everything they need. You better let the nurses know so that they can give you cure like if you don't speak up they won't...they won't come to you like they thought that you are OK. They have to go to them always, you know, direct to them and say I need this...I am feeling...you know, I need some medications or something for my pain otherwise they won't.

She addressed the issue of openness by insisting that Filipino-Canadian patients should speak up and let the nurses know what they need and how they feel; otherwise, the nurses will assume that everything is fine and, therefore, will not come. Although Ester sometimes found the nurses very busy, and she said jokingly that they never came, she noted that they eventually came and pointed out that there were times when she had to go to the nurses' station herself to remind them that she was still waiting. It

is, therefore, necessary not only to speak up for oneself and to speak directly with the nurses but also to take the initiative to approach and remind them.

It is also important to remember that determining the degree of openness and disclosure in communicating among the Filipino-Canadians depended largely on whether they considered the individuals "one of us" (*hindi ibang tao*) or "not one of us" (*ibang tao*). Victor, for instance, recalled how his older sister knew that their father had terminal cancer before everyone else in the family knew:

> In 1995 May, he did not like to go to the doctor. We were forcing him, he did not like until one night he could no longer breathe. We therefore called an ambulance, but the doctor has not said anything yet because Tatay was rushed to emergency for three times. But for the very first time I guess the doctor said something to my *Ate* [a title given to an elderly sister] eh my *Ate* on the other hand, she did not say anything. She did not tell us. That the case of Tatay was terminal at that time...On his birthday, it was a big birthday party. He was still able to reach his 67th birthday. He died December 9.

Although his sister did not tell him, he had a sense that the doctor had said something to her. Victor noted significantly, "She just did not tell 'other people' (*ibang tao*) but she told me." His sister knew in May but told him 3 months later—in August. In November, they prepared a big birthday party for him. Who gets what information depended on the criteria used to determine who would take responsibility, the weight of responsibility, and how responsibility is shared among the family members. His sister was the eldest among the siblings, and he was the youngest. Their parents were his sister's dependents in Canada, so she assumed responsibility for all of them. Although their mother was the closest to their father, she must have been the last to know because they deemed her most vulnerable and thought that she would have the greatest difficulty accepting his death. "Other people" or "not one of us," who were

obviously not part of the family circle, were not told that their father was a terminal case. This showed that information was kept among "one of us."

Another example that illustrates the same dynamic within the family circle was Jess's observation. Jess, who had two heart attacks at the age of 47, thought that he was "Westernized"; he had been able to adapt and was, therefore, no longer as demanding as those who were new in the Canada might be:

> Ya as far as the care I received I can say that ya I received...I haven't had any problems with nursing care that I got, and I am sure if I did, the hospital staff will know about it...I think if there will be problems in the way care is given and the way care is received it...it could very well be because of communication. Right? Me being a patient is unable to tell the nurse exactly what I want, what I require, and I call my daughter or my children or my siblings to explain. They speak the Philippine language as well and they are able to communicate what's going on or they might be able to communicate in a round about way that who ever is listening the nurse might not be able to interpret properly and then there is a misunderstanding.

Jess had not experienced such a misunderstanding but had seen it happen and believed that the crux of the matter was a simple case of misunderstanding in communication. He imagined that if he were a patient who was unable to express his needs to the nurses directly, he probably would call his family members, who spoke better English, and ask them to speak on his behalf. However, the nurse might misinterpret, and, consequently, a misunderstanding might result. Asked how the patient would handle the situation, he gave several possibilities. Jess raised four points. First, two typical reactions are crying and remaining quiet. Second, the matter was discussed within the family circle. Third, the matter was not brought to the attention of the head nurse. Fourth, family members might not be able to express themselves adequately. In connection with the first point, Jess alluded to his mother, whom he described as vocal and, therefore, able to express herself.

He further speculated that someone who had immigrated directly from one of the provinces in the Philippines to Canada and who had no background or understanding of his of her rights might think this was normal and, therefore, would remain silent about the situation. The another point he raised confirmed the dynamics described earlier about the important part played by members within the family circle and how Filipino patients relied greatly on them as "one of us" (*hindi ibang tao*). Therefore, it seemed logical not to address the problem with the head nurse, who was considered "not one of us" (*ibang tao*) in this situation. He thought that the best way to address this was to make Filipino-Canadians aware of their rights as patients:

> That they have the right to say and not just to brush it off and just remain silent about it. On the flip side, as far as the Canadian culture is concerned there is a better understanding of what is going on within this because the Philippines is just one culture. There is the Chinese, there is the Indonesian, ya even people Bosnia all kinds of different cultures.

Florence placed the stress on how essential openness was in nurse-patient interaction and in establishing a good nurse-patient relationship. This was clearly manifested in many examples previously presented in varying dimensions, from the almost impersonal to the most personal, from the superficial to the deepest and closest. The length of time the patients stayed in the hospital either fostered or hindered their relationship with nurses. However, Florence made friends with them easily regardless of the length of her stay.

> Its...aahh...I think it's my basic nature to be more to be open and I guess when you're open then people kind of open up to you too. So, in that sense I have no problems really relating with nurses even from different culture ya.

A lengthy stay in the hospital can help both the nurses and the patients get to know each other personally, but Florence was inclined to believe that the quality of the patient-nurse relationship she created had to do with her friendly and open nature.

Anita found that "not being open" was part of her "character," whereas Florence found that "being open" was her "basic nature." The contrast between Florence and Anita indicated the difference between their personalities. Being open or not being open is, therefore, something that has to do with personal idiosyncrasy and is unrelated to culture. Although Florence and Anita were anxious to see and interact with Filipino nurses in the hospital, neither had problems relating to nurses from other cultures. Florence reiterated her point later by saying that openness begets openness:

> So if you are cooped up in your own self...in your feelings then...aahh...there would also be to them a wall between yourself and them and it would be much harder for them to relate to you and vice versa. So the openness has a lot of things, you know, a lot to do with that.

Florence echoed Anita's realization that patients need to tell the nurses exactly how they feel or it will be difficult to establish a nurse-patient relationship. Another point that Florence raised was the fact that she was not hard to please: She did not have very high expectations and did not set high standards.

> I am very easy to please. I am very easy to please. I don't expect a lot of things. My expectations aren't, you know, I don't really set standards and expect the nurses to be here in 3 seconds within my buzz, you know, I know they have other things to do so I'm quite patient and I'm...I try to understand their situation too. So I am not demanding. I just ya I just make do with...ahh...what they give me you know. If they could come to me in 5 minutes fine so long its not an emergency it never was I guess so...I am very pleased [laughing] I do not expect too much [laughing].

Anita's preference for keeping her feelings and needs to herself and Ester's suggestion for Filipino-Canadian patients to be forthright and to speak directly with the nurses about what they need and how they feel indicate that articulating their needs and feelings is a real challenge among Filipino patients. Florence, however, attributed this challenge in communication to the patients' limited ability to speak the language:

> Maybe patients who doesn't have, you know, who can't communicate well I think they will have problem because if I have...you need...if I feel something then I could adequately describe it to them and be able to tell them in precise terms what I want so somebody else can...will come to a hospital with very limited English that would be a horrible for...a different...a nurse from a different culture to understand the patient's view. So I think language has a big thing to do too with how you know...how the care you would be getting is impacted by a nurse from a different culture. How you can make it. I guess it's very important.

The ability to communicate in English and express oneself adequately relates to points raised earlier in Jess's observation. The importance of language and its impact on the care of the physiological and psychosocial dimensions of the patients have emerged in several instances as Filipino-Canadian patients recalled their experience of being cared for in the hospital. The next subsections are devoted to describing the various ways in which Filipino-Canadian patients chose to express themselves: the languages of words, gaze, touch, and food.

Language of words. In communication, the use of language can either facilitate or hinder understanding between or among individuals. Several Filipino-Canadian patients admitted that when they first came to Canada, their English was not very good, but neither was it too bad. Many Filipino-Canadian patients preferred to have nurses from the same culture because they did not have to worry about speaking in English. In the previous example, Florence cited that Filipino-Canadian patients might encounter problems if they cannot adequately express their needs or describe their feelings to the nurses from other cultures. She therefore stressed that the patients' ability to express themselves in the language of words could greatly affect the quality of care given by nurses from other cultures.

Nurses can understand the patients' needs and what they are going through by observing closely nonverbal cues such as facial expressions and bodily gestures.

However, these are very subjective in nature and would still need the language of words to validate the observations. Brenda, therefore, reiterated the importance of language in her statement, "It is important to try to adjust first of all to the language" or else there will always be a need for an interpreter. This was particularly true for all immigrants in this study, who had to learn how to communicate in English as a second language. Carlos emphasized the great challenge Filipino-Canadian patients and the nurses from other cultures had to face if they were not able to speak each other's language. Ester's husband, for example, thought that learning and polishing his French was important, as this improved an individual's chance of obtaining employment with the federal government.

Florence pointed out one of the advantages of having nurses from the same culture: She was able to communicate with them in her language literally and figuratively.

> In a way, it is nice to have someone from the same culture and you could speak your language not only literally speak your language but figuratively speak your language, you know, they know where you are coming from kind of thing.

> Well, its not that they [nurses from another culture] didn't understand but it's just that when you meet Filipinos, they get the jokes. Of course, anything that refers to the culture in the Philippines they can make a joke out of it, right?

She elaborated using jokes as an example. Words connote meanings that might be metaphorical or symbolic in that language. Unless the nurses speak the language and have been exposed to the people, their place, and their culture, it would be impossible for them to perceive and understand these seemingly hidden meanings:

> They [nurses from other cultures] wouldn't know anything about *jeepneys* [four-wheeled vehicles that are popular in the Philippines] or *adidas* [a popular brand name of sports shoes]. They wouldn't know anything about this kind of words and so you can't talk about those things with them. Whereas with "another" [*kapwa*] Filipino—with the same culture you would

> joke around those common things but I don't think it has anything to do with their efficiency [laughing] its just, you know, being able to relate better but even with the Caucasian nurses, I guess it is also because I stayed there for a long time that I got to know a lot of them.

Florence also pointed out that besides understanding her, not only literally but also figuratively, nurses from the same culture knew where she was coming from. They were able to make and enjoy jokes because they understood their context in the Pilipino language and culture.

Ignacio observed that the maintenance staff in the hospital were mostly Filipinos and recalled particularly a male Filipino nurse who took care of him. He was glad that he could practice his native tongue, Tagalog, with some of them. He explained that none of his children learned to speak Tagalog because he never used the language at home. The only opportunity he had to speak it was when he encountered fellow (*kapwa*) Filipinos. When asked if he preferred to have a nurse from the same or from other cultures, he said it made no difference for him. He also recalled seeing a female Filipino nurse in the operating room when he had his first surgery:

> I didn't notice it for long because by that time I did, I went out like a light already. But, I saw her and she was the one taking care of the instruments to be made ready. All that I do remember...telling her, "you must be *kakababayan*" [a fellow countryman] and she said, "yes."

Although Ignacio did not recall seeing a Filipino doctor, he said he would not be surprised if there was a Filipino doctor there. When asked what he would do or say to the staff if he had to be hospitalized again, he said,

> I sure would like to chat with them about the Philippines for one thing. Although, I do remember having one. I believe she was a nursing aid, I told her that when I left the Philippines, Macapagal was president. She said, "Who is Macapagal" [laughing]. Well, because that was too far back [laughing]. Oo, she wasn't born yet. She didn't know what I was talking about [laughing].

Ignacio raised the issue that even if he could speak the language with the nurse aide, there was evidently a generation gap. The nurse aide was too young to be aware of the things that happened during his time and to understand his context. It was not only the literal, figurative, and cultural contexts but also the historical context that they had to contend with in communicating with each other.

Brenda felt the same way about having nurses from the same culture take care of her and recalled that every time she was hospitalized, there was at least one Filipino who looked after her in the day shift:

> It's nice. It was nice. Yeah, here you are not...at least you know, you can speak Tagalog. You don't have to worry about expressing. Particularly, making mistakes in expressing in English. That sort of thing. Yeah, but they are very good. The Filipino nurses there, I think they pamper. Specially, if their patients are their "fellow Filipino" *lalo na yong kapwa nilang Pilipino*, they pamper them. They do. They do, yeah.

Brenda confirmed what the other Filipino-Canadian patients felt about not having to worry making mistakes in English if nurses were from the same culture. She was able to express herself freely with them. She perceived that Filipino-Canadian patients were pampered by nurses from the same culture because they were "fellow Filipinos," or, in other words, "one of us" (*hindi ibang tao*). She contrasted them with nurses from another culture, whom she labeled "Whites" and therefore obviously considered them "not one of us" (*ibang tao*):

> The Whites, some of them, can be *ano*..."just stick really to their task" *talagang trabaho lang*. "They stick to the task at hand" *trahabo lang sa kanila*. They will ask you how you were but other than that that's it because, of course, they are also busy like that but the Filipinos they take the extra time to ano...to talk to you such as, "From where in our country do you come from?" *Taga saan po kayo sa atin?* Yeah, [laughing] they'll ask you those things while the Whites they'll drop and it has to be done.

Brenda's observation resonated with what was mentioned previously concerning the professionalism of nurses from other cultures because they adhered strictly to doing their work within the allotted timeframe.

> Ah that is all that I noticed, they really pamper you. One thing, if you really need, they volunteer. Yeah, I am sure they do the same thing to the to the Whites too. Yeah, my experience, of course, specially, she was my godmother [*ninang*] [laughing]. Of course, she takes good care of me. Yeah, so it was...it was nice yeah.

She speculated that the White patients must be pampered by the White nurses too. However, she raised the fact that one of the nurses from the same culture was her godmother, which brought forth a different level of relationship. Godmothers in the Philippine culture are very much considered within the family circle and, therefore, reckoned as "one of us" (*hindi ibang tao*). She believed that even if she did not have any relatives here in Canada, she was confident that someone would look after her. She was almost certain the nurses would take care of her, and she contrasted this to the situation in the Philippines, where nurses relied on family members and relatives to look after their own patients, because there were more patients than the nurses could handle:

> I think even if you don't have any relatives here...you may not have anybody and you get hospitalized here [*yong wala kang ano*] somebody has gonna look after you. There are nurses, who's gonna "really take care of you" [*talagang aasikasohin ka*], whereas in our country, you really need people to look after you because, from what I can hear the nurses there, they don't really do their job. It is the [family/relatives]. The one who do their work are the relatives.

In the Philippines, the family members and relatives were expected to do everything for the patient except administer medication, which was strictly the jurisdiction of the nurses and doctors, whereas in Canada, patients are concerned about the legal aspect of the practice. Patients in Canada have the right to sue the nurses and other health professionals when they are mistreated or when there is an obvious malpractice:

> Yeah, so I have friends, who went home to look after their sibling, who had cancer, and they were really exhausted because they have to do everything for her there in the hospital where they went and they have to buy the medicine every time they need medicine they have to buy them and then you have to wait again for a doctor to administer the medicine or a nurse to give it to you. Yeah, the only [difference] here, they have to take care of you because, otherwise, if you...if they are always *ano* there is always an option. The people here, they can always sue just in case you are not properly treated. If a doctor do something wrong, you can always sue them for malpractice ya ya ya.

She observed that regardless of whether patients have family members and relatives, patients in Canada are well taken care of by nurses and other health professionals.

Carla, however, brought forward an entirely different perspective to this matter. She observed that people from other cultures are different. They speak more quickly and are better able to express themselves in English (*magaling magsalita*). She admitted that her English was not very good. In fact, she had great difficulties adjusting to the language at first. Her English was slow and formal. She had to "pick up the words one at a time," and it was only after staying in Canada for some time that she learned and adapted to the "colloquial way of speaking." Carla summarized that in immigrating, "you try to adjust first of all to the language…you have to really learn how to communicate." Overall, Ester's husband and Jess were correct in saying that Filipinos who come to Canada directly from the Philippines without any other experience abroad might find that adapting to other cultures and languages takes time and a great deal of effort. However, there is more to the language of words that makes communication even more interesting. There are also the nonverbal cues that nurses and other health professionals have to understand as they communicate with Filipino-Canadian patients.

Language of gaze. One of the ways Filipinos communicate with each other is through their gaze. Filipinos are known for having very expressive eyes. In public places, a slight bowing of the head is a more appropriate way of greeting someone who is elderly or someone in authority. However, smiling and at the same time gazing at each other's eyes and raising one's eyebrows once or twice is a more casual way of greeting a friend or someone who is of equal stature. A nod may be a way of saying "yes," but for most Filipinos a more reassuring gesture of approval is by gazing at each other and at the same time raising the eyebrows once or twice or winking an eye. A hard stare and the meeting of the eyebrows may mean disapproval or anger. An evasive look can mean that the person is either concentrating or hiding his or her feelings, whereas lowered eyes might indicate either respect or indifference, depending on how these are used in combination with the body posture, demeanor, and attitude that goes with these nonverbal cues.

Florence, who was transferred from one hospital to another because of a complication during pregnancy, recalled that because of her serious condition she did not actually notice anything:

> When you are serious, you do not notice anything anymore [laughing]. When you are semiconscious, the only thing I saw were their tensed faces [laughing]. I saw in their faces the stress they were going through. Actually, I felt things were hazy. Eh my memory was hazy at that time but I knew they were all crazy *pinagkakaguluhan* going about me. There were a lot of them hovering around me.

In spite of her semiconscious condition and hazy memory, Florence still noticed the tensed faces of the nurses and was aware of how they were hovering around her. This apparently showed the social sensitivity that Filipino-Canadian patients referred to as *pakikiramdam*. Florence found her two hospital experiences different:

> In the second one the rapport with the nurses was not so establish. In the beginning, when I was in a critical condition, two nurses were assigned to take care of me. I know and saw from their faces that they were concern but because I was semiconscious and I was under the influence of a lot of medication I could not...I can not interpret their gaze...or what they tried to communicate with their gaze...the only thing I saw in their faces was their worry...their concern...that was what I saw.

It was important for Florence to decipher what was going on around her. Had it not been for her critical condition, she would have been able to see for herself what the nurses conveyed through their gaze and may have had a more detailed interpretation than just the worried faces that showed their concern for her.

Karen explained that the eyes can express a lot of things. Feelings such as anger, frustration, or indifference can be expressed through one's gaze:

> It depends if the person knows how to see *tingin* what the other is trying to convey with their eyes but there are people who can disregard it. But the eyes are an expression of a lot of feelings. It can express anger. It can express the will to do something really that will hurt people. You can see that in the eyes. That all depends if the person knows how to read [*magbasa*] whatever is being conveyed by the gaze then you will understand.

She recalled that the Black nurse whom she claimed as having mishandled her was not able to look at her directly during the interaction they had. When asked how she perceived the nurse's gaze, she said,

> It means that the person is thinking about something that may not be good [*maganda*] because the nurse and the patient should always look at each other straight in the eyes especially if you are giving instructions. You don't give instruction where you are looking somewhere else. It has to be an eye to eye contact. That is the way I feel. That is part of it eh that is part of the human reactions eh from the way the nurse looks [*tingin*] at you alone and the way the nurse touch [*paghawak*] you, you know already yes that is if you are mentally alert.

Karen closely linked the way the nurse gazed at her with the way the nurse touched her. Apparently, the language of gaze cannot be isolated from the language of words and touch. They come as a package in any patient-nurse interaction.

Karen stressed that the basic condition for the patient to read and interpret accurately the language of gaze, touch, and words is to be mentally alert. In the previous example, Florence was semiconscious, hence unable to read and interpret what was going on around her. In the succeeding example, Remy was not certain how to explain gaze and what it conveyed:

> You can not really...because *kuwan* sometimes by their gaze [*pagkatumingin*] you think they will...especially if you call when you need something eh they will look at you...there are some whose gaze are different [*ibang tumingin eh*] but you should not really pay attention to it because that is probably just the way one looks [*tumingin*]. What I mean to say, there are those whose gaze are *suplada* because eh there are gaze that is when you call they immediately come to you and look [*titingnan*] at you. Eh whenever...as long as *kuwan* when they pass you by [*pagdinaanan*] they look [*tiningnan*] at you.

Remy pointed out that there are distinct ways of gazing which one should not be bothered with because they are probably just a matter of style. However, gaze was the number one criterion she used to determine if the nurse was *suplada* or not. She further contrasted a bad gaze from a good one:

> Sometimes there are those who have a bad look [*masama tumingin* eh]. It is like looking angrily at you. [*Yong para kang iniirapan*]. Do you know that? It seems like you... it is like you are not...it is like discriminating you the gaze [*tingin*] is different like that. *Nangmiminos* that is it...it is like discriminating that is why sometimes eh the gaze *tingin* is bad.

On the one hand, Remy actually identified an angry gaze and a discriminating gaze as bad. An angry gaze (*iniirapan*) involves a sharp and scornful look and a swift change in the person's focus to evade further encounter, whereas a discriminating gaze (*nangmiminos*) includes looking from head to foot, making the person being appraised feel smaller or lesser. *Nangmiminos* can be literally translated as "the act of diminishing or devaluing another." A good gaze, on the other hand, is well meaning. One is able to see in the other person's eyes kindness and tenderness:

> To look kindly *mabuting tingin*, eh she is *makuwan* ah *makarinyo siya maganda siyang tumingin*. When you call it seems like eh she looks *titingnan* at you *eh*. It does not seem to hurt you like that *hindi ka parang nasasaktan*.

The patient sees that the nurse has every good intention—that she does not mean to hurt.

Nancy applies the angry gaze with other types of social interaction. She explained that when her friends are angry with her, they look at her sharply. Through gaze she also knew when her friends envied the way she dressed or despised her because of her attitude or her action. She described such a gaze as being sharp and angry (*iirapan ka umiirap*). In Ilocano, it is referred to as *nagkuskusilap*. Nancy described the puckering of the lips or mouth in depreciation when one is extremely angry or when one is envious (*sinisilmar*). *Irap* or *ismir* is to direct a scoffing expression around the lips at someone.

Again, the focus is not just in the eyes. The language of gaze involves the whole facial expression. It includes the forehead, eyebrows, nose, mouth, and how the jaw is set. I will not go into details of how all these facial parts are used alone or in combination to communicate. Besides gaze, touch is also a rich communication source of nonverbal cues when interacting and relating with Filipino-Canadian patients.

Language of touch. Another way Filipinos communicate with each other is through the language of touch. The Pilipino language is rich in its vocabulary for touch. It can be literally translated as *hipo*, synonymous to *himas*, *haplos*, and *hilot*. For some Filipino-Canadian patients, these terms had the same meaning, but most used these terms interchangeably. There were those, however, who not only linked touch with physical contact but also associated it with the volume and tone of voice

and the attitude the nurses had as they talked with the patients in the process of giving their nursing care. In the previous chapter, Urlando alluded in a more general way to human touch as oppose to being inhuman. In this section, I describe these views by giving examples based on the hospital experiences of Filipino-Canadian patients.

Lito, for instance said, "I do not think there is any difference between *haplos* and *himas* eh. For me, there is no difference eh." Thomas had a similar view as Lito: "In my opinion they are all the same. No, there is nothing I can say with regards to having experienced nurses *na mabigat yong kamay*. For me they are all the same." *Mabigat ang kamay* is literally translated as "heavy hands," but figuratively, it is a Philippine idiomatic expression referring to someone whose touch hurts.

Remy, on the other hand, was not quite sure how she could best explain the difference because she had not experienced being hospitalized in the Philippines, and when she was hospitalized in Canada not one of the nurses who took care of her was a Filipino. She agreed, however, that *haplos* was common among Filipinos in general and yet did not perceive the nurses doing it in the same manner Filipinos did it.

> They [the nurses] touch you *hinahaplos ka* when you feel some pain...then you tell them where the pain is and they will look at it and touch it like that but not in the manner like *haplosin ka*. Not really. Not really and yet there seem to be no difference. They are all the same. *Himas* is like a massage *minamasahe*. *Paghaplos* there is a slight touch of the nurse's hands against your body *dinadait*. A brief *haplos* is like you are *dinadampot* only like that. The *hipo* is as I said like *dinadampot*. It is just like touching you *hahawakan*. *Eh* so it is really like *ano* sometimes I can not also distinguish *kuwan* the difference *kuwan*. But it seems to be one and the same *eh* because *haplos* is touching you *hinahaplos ka* in the back but the *himas* there is a little bit of pressure *madiin* like that.
>
> Eh the *hilot eh* for example you have some pain in the back so *hinihilot* and they put pressure *dinidiin* that is *kuwan* [heavy] because and also when you have *pilay* [sprain or dislocated bone] then you are given a *hilot* but the nurses do not do *hilot* there is someone who is really trained to do *hilot* like

> an acupressure ah I can not say... There is *maghihilot*—someone who does *hilot* for *pilay* like that.

Generally, these terms seems to be used interchangeably by Filipino-Canadian patients, but after listening to all of them, I have concluded that there is a difference in terms of the purpose, depth of pressure, length of physical contact, stroke applied, effect it produces, and who is suppose to do it. Remy, for instance, attributed to nurses *haplos* when understood to mean palpation, whereas *hilot* is given by *manghihilot*:

> Ay for instance the nurse comes and *hahaplosin ka.* You will say, for example, this part of your body is painful eh so she will look at it and *hahaplosin niya* and then she will tell the doctor to find out what it is all about. *Hinaplos—dumaan yong kamay niya sa iyo* the nurse's hand passes through you. It is just slightly touching you with her hands
>
> *Hilot* no they [the nurses] are not *nanghihilot* eh I just do not know but what I know is that if they say *hilot* you go to a *maghihilot.* That is where you have the *hilot.* That is what I know. Yes.

Although she never went to one herself, Remy attested to the fact that there were several *maghihilot* in the city. Ignacio, who has been away from the Philippines for more than 45 years, remembered the *maghihilot* and associated *hilot* with what a physiotherapist did on his back:

> That is the *maghihilot.* I had that experience here when...but this was done as part of my rehab. There is somebody from the physiotherapy...There was...they make sure that my breathing...they gave me some breathing exercises and then they rub my back like that. She was a physiotherapist. Ah maybe she was...I do not know...she was from physiotherapy. They call her physiotherapist. I did get very good treatment from them. They made sure that by making *hilot* on my back it will help me because when a person is bedridden they say they've got to do some breathing exercises.

In somewhat similar fashion, Nancy described these terms as follows:

> *Hilot* is a bit strong—the pressure applied on your back or whatever. *Haplos* it is just touching you *hahaplosan* in the surface *ibabaw* nothing is squeezed the touch is only light and that's it.
>
> *Himas* eh *hihimasin ka* it is like squeezing you—it is holding you with two hands and squeezing you *pisilpisilin ka* that's the *himas.*

> *Masahe* is different because you are not squeezed *pipisilin* just press there press press. That's it yes...it is like putting pressure *dinidiin* only while *himas* your muscles and the rest of the body are being squeezed *pinipisil-pisil.*
>
> *Hipo* [laughing] *hipo* it is only touching *hihipuin* you while asking you "how do you feel?" Just like that it is touching *hihipuin* you only. That's it.

As far as she can recall, none of the nurses who took care of her gave her any of these except when she was given a sponge bath:

> When I can not have a shower *naliligo* the nurse gives me a sponge bath *pinupunasan* throughout my body everything and then she change *papalitan* my clothes and that's it and then they give me oxygen they bring me to the washroom and that's it.

Nancy's perception of touch shifted to a more holistic sense, which resonated with Karen's experience. But note how Karen sounded more certain that there was a difference. She described *hipo* in a more general way, similar to the English term "touch," as in "the nurse touched your hands." She said that with the way a nurse touched (*hipo*) her, she was able to know if the nurse liked or disliked her. Given that the patient is experiencing severe pain in the site where an IV needle has just been removed, Karen referred to this as *hipo*—a tender touch. Karen explained that the nurse looked at her hand and then with one finger touched the area where the IV needle was inserted and looked at the affected area to find out what was wrong. She assessed the area by touching and looking at it, and then she tried to fix it.

Touch in this sense is equivalent to a physical contact that is applied when one is trying to palpate. Another word in Pilipino for palpation is *salat*, whereas *himas* is a kind of touch that is preparatory to a massage. Karen said there is a certain degree of pressure (*diin*) applied in doing a massage. It is done when there is some pain or soreness in some body parts. She described *haplos* as a tender touch. A tenderness in

the way the nurses express verbally their caring attitude goes with the physical touch. She explained that *haplos* was best exemplified by nurses who were personal in their approach:

> "Good morning ho, how are you [*kamusta ho kayo*]? Come on, let me change your dress [*Halina ho kayo bihisan ko na kayo*]." First of all, there is respect. That is one thing. Respect "Come on, so I can get you dressed [*Halina po kayo para mabihisan ko na kayo*]." And then now the way she holds you is really different. There is the kindness and the generosity because it has the human touch. There is the emotional touch especially when they can see that you are in pain. With a lot of respect yes and then with generosity and kindness.

Karen repeatedly stressed that there should be respect. Human touch in this sense encompasses not only the physical contact but also the whole conduct involved in caring for someone: the gaze, voice, tone, and demeanor of the nurse. Karen added that there is this emotional touch involved, especially where there is pain.

> For example, what happened to me in the hospital. Just from the voice alone I already sense her being authoritative eh. You can not be like that. A nurse should never be authoritative that is having no respect eh. "Why did you do this? Why did you do that?" She said to me. "O don't do this. You stay you stay." O she was giving orders all the time. You don't do that to patients. Never should that happen. *O basta* the most important thing always is TLC specially if your patient is very sick and is a senior [laughing]. I noticed that it is really respect especially with seniors I said why such a thing happened to me. I said maybe that is part of the...you can not accept racial discrimination because she was darker than I am eh.

Again we see how shared human identity (*pakikipagkapwa*) is played out in this patient-nurse interaction. She denied the possibility of racial discrimination and expressed further how nurses are expected to treat patients as though they were "one of us":

> They can't treat their patients like they were the boss [laughing]. You treat your patient as if they are one of you. Yes there's got to be respect. If you have respect that means you love your work and you love your clients and your patients.

As discussed in the previous subsection, being treated as "one of us" (*hindi ibang tao*) meant giving personal care, which meant the same thing when they used the phrase

personal touch. When asked to expound more on what she called TLC—Tender Loving Care—she reiterated all the qualities she expected nurses to possess:

> If the nurse is tender then she has kindness, respect, love and generosity. It is the way the nurse says things. It is how you talk to your patient with a lot of respect and how you for example give the medication, the way the nurse fix the bed she can not just order the patient, "you turn that way, you turn the other side." I went through all that eh. *Ay naku!* Maybe...I do not know...if it is the culture, I can not understand.

Karen's experience with the Black nurse who mishandled her indicated that she had certain expectations from nurses that were not met. Karen differentiated Filipino nurses from Canadian:

> Our Filipino nurses always have what we call TLC—tender loving care that is outstanding among us eh even with our nurses in the hospital even among male attendants, isn't it? Yes, that is true in the hospital. Yes. Even my home caregiver here, even if you converse with them. There was a Canadian home caregiver who came to me. If she were a Filipino it would have been different. Canadian always seems to be business-like. They do not have that touch, eh! That is very common among Filipinos even among helpers *katulong.* That has always been our outstanding characteristic traits. Yes Filipinos are affectionate eh *haplos* is an expression of affection eh.

Karen referred to *haplos* as a human touch involves not only involve a physical component but also contains an emotional component. When asked how she would have preferred to be touched, she replied,

> The nurse should never put pressure and not to show any sign of disgust or anger. That should not be. They have to control those kinds of feelings especially those negative feelings. They have to be controlled eh. There are many patients who even react more intensely. I am a very cooperative patient. There is nothing much to say about me. They tell me what to do, I do it. I don't say no as long as they explain to me and then the way you explain has to be...verbally you can be very kind. Yes if verbally the nurse is not kind you will be forced to use force.

Kindness reemerged in the data set when Filipino-Canadian patients talked about touch. Karen was a little ambivalent when I asked if it was the responsibility of the nurses to give the patients *haplos*:

> Yes, no Yes, except, for example, if you tell the nurse that you have some pain somewhere in your body then the nurse will also try ***nagsusubuk*** but when she does that the nurse is careful when you have pain in here, for example, here in your head, your neck, she does not out right give ***haplos*** there eh those are dangerous area eh. And the nurse is not expected to do that. As long as the nurse is very professional or unless the patient know the nurse very well or a nurse who is by nature very loving. There are characteristic traits especially the nurses so you can not treat all nurses the same.

Generally, there is a respectable space between the patient and the nurse. It takes some time before a nurse and the patient becomes comfortable with each other to warrant a *haplos*. The nurse and the patient must know each other to a certain degree. Otherwise, such a touch might be misinterpreted, especially if the patient is of the opposite gender. Karen emphasized that as long as the nurse is very professional, the gesture of touching can be a sensitive issue. Years of experience can also train nurses to acquire the skills of personal touch, otherwise known as human touch.

The importance of the emotional component was confirmed by Donna's experience with a nurse who inserted the IV needle:

> That is more psychological ah because the treatment was really discourteous and rude (*bastos*). If not for that...that is another and then the way she injected the needle to me was painful (*masakit*). It was really painful like. It was like boxing me there in my hands, in my arms. She really did not have any gentleness at all.

When asked what she meant by gentleness, she explained that it was not only being gentle in touch but being polite as well. For Donna, it was the nurses' attitude that counted most.

Lito had a similar experience with a hospital staff member who was inserting the needle everywhere because she could not find his vein. He found out that she was, first of all, a replacement worker. Second, it was the hospital worker's first day on the

job, and he was the first customer or patient she saw. He did not recall her giving him any comforting touch (*haplos*).

Painful experiences do stick out in the memory of most patients, but when counterbalanced by some comforting touch, pain seems to be diminished. Lito said *haplos* gives temporary relief to anyone who is in some sort of physical or emotional pain. He recalled only one Filipino nurse who gave him *haplos*:

> The only good thing about the nurse, I already knew, is she gave me a pudding [laughing] when I requested for some. The others did not. Eh they said it was prohibited. Of course, I understood that it was prohibited for me because my blood sugar went up at that time eh. I was always thirsty then.

In a later incident, Lito stressed the fact that he and the nurse already knew each other even before he was hospitalized. He shifted his perspective of touch from one that was physical to one that was psychosocial in nature. Unlike the former incident, the latter did not even have anything to do with the physical. He recalled the pudding that the nurse gave him. This brings us to another mode of expression that is popularly used among the Filipinos, the language of food, which will be discussed shortly.

In summary, *hipo*, *haplos*, *himas*, and *hilot* generally mean "to touch." However, based on how the term is used and factors such as the purpose, depth of pressure, the length of physical contact, the stroke applied, the effect it produces, and who is supposed to do it, each of these terms would have different connotations. The person who is giving and receiving the touch, and the context how the touch is given and received or reciprocated, made a difference in the meaning conveyed by the touch. *Hipo* and *haplos*, for instance, connote more than just palpating or soothing; they also involve caressing, whereas *himas* and *hilot* are terms that connote comfort,

relief, or healing in a more technical sense, as in the traditional bone setting, massage, or physiotherapy. Furthermore, all of these terms were also used in a more holistic sense that involved not only physical contact but also the emotional component that goes with the touch. Filipino-Canadian patients referred to this as personal touch or human touch, which includes the tone and volume of voice, and the attitude expressed by the one who is giving the touch.

Language of food. Food has always been a means for socializing among the Filipinos. It has also been used as a way of indicating that someone is welcome or of expressing one's gratitude. There were many instances where food was deemed most appropriate as a way of communicating. When asked, for instance, what she would tell those two nurses who seemed outstanding in her memory if she had the opportunity to talk to them again, Florence had a long list at hand. She would ask them if they still remembered her, "say hi" to them, and update them on what was going on with her children and her. She would ask them in return what is going on with them:

> Ya I'll tell them thank you for that special attention and for all the things they've done to make my stay comfortable. Actually the second time I sent...for the attention they gave me at [name of the hospital], I sent a...I forgot if it's flowers or a cake or ice cream cake. I sent the nurses something after I was released to thank them for their attention so and then I sent them picture a picture of myself and [name of the second baby] 6 months after. Ya so I try to express my gratitude by flowers and cake and ya because they did, you know, help my stay be, you know, very comfortable despite being in the hospital [laughing]. Ya.

Florence could not remember exactly what she sent the nurses after she was released from the hospital the second time but noted that two of them were food items—cake or ice cream cake. It was her way of showing them gratitude.

In the previous section, Laura mentioned offering something to the Filipino staff who were on night shift just to "watch over" (*bantay*) her husband because he never said anything to the nurses when he needed to urinate. Evidently, she did not expect the nurses or other hospital personnel to monitor and assist her husband in going to the washroom. She considered this a special favor, and Laura, therefore, felt obliged to offer something in return:

> I bring with me donut and chocolate because it pays to play politics too. They [nurses] are very good even those in ICU...There are many Filipina [nurses] but outside the ICU. There is one Filipino in [the] night shift who was particularly kind. The Whites are OK but...not really exactly like the Filipinos with whom you are able to say that...they [Filipino nurses] are so much unlike...the Whites. The Filipina, they are very caring.

Laura stressed the fact that she felt freer to express herself to nurses from the same culture than to those from other cultures. She said that the Filipino nurses were very different from the Whites nurses. With the Filipino nurses, she was able to say what she needed to say. Laura used the phrase "it pays to play politics" in describing her action of bringing with her donuts and chocolate to give the nurses on night shift. In North American language, giving something to someone in return for a special favor can be interpreted as playing politics, but in the Philippine culture, the act of giving someone something, particularly food, was the most appropriate and acceptable way of expressing what they call a "debt of gratitude" (*utang na loob*) for helping her and her family in times of need.

It meant a great deal to Laura to find Filipino nurses in the hospital, as there was no one in her family on whom she could rely, except her sister-in-law or a cousin, who would relieve her when she went to work. There were situations, however, when neither Laura nor Lito's sister nor his cousin could be there for him:

> I have to bribe the Filipinos who are there at night to watch over him. They usually say "Don't worry" but I tell them, "He does not say when he feels like urinating." So there is a guy there who is good. I do not see the young male nurse, who used to be there. He said he will go and see him every night. OK.

Laura used the word "bribe" to express what she wanted to say in English, but *bribe* is defined as "a price, reward, gift, or favor bestowed or promised to induce one to commit a wrong or illegal act or is anything given or promised to induce a person to do something against his wishes." Bribery is the act or practice of giving, offering, or taking rewards for corrupt practices. It is applied both to the one who gives and to the one who receives the bribe, but especially to the giver. If *bribe* was the appropriate word, it is literally translated in Filipino as *suhol. Utang na loob* was therefore the more appropriate term in this context. In reality, Laura does not have to offer the nurses anything, because whether they are from the same culture or from other cultures, they believe that taking care of the patient is part of the services they perform. Laura, however, thought it a special favor when she asked the nurses to "watch over" her husband and felt that she owed the nurses a "debt of gratitude" (*utang na loob*)—giving a gift (often food) in return for a favor rendered. For most Filipinos, special favors like these have to be reciprocated. In contrast, *suhol* is an act of payment or receiving a reward for a false judgment or testimony or for the performance of something known to be illegal or unjust. Nevertheless, *utang na loob* has an entirely different context when used among Filipinos, hence the expectation that families or relatives attend to the needs of their patients. This concept of *utang na loob* will be discussed extensively in chapter 6.

Spiritual Dimensions

Filipino-Canadian patients and their families were also anxious to have their spiritual needs met while in the hospital. Family members/relatives were usually expected to ensure that care in the spiritual dimension was provided to patients. Although they did not think about it at the time, in hindsight, both Anita and her husband noted that there were no ministers, priests, or nuns in the two hospitals where Anita delivered her babies. This puzzled both of them. Anita thought that perhaps it might help if a nun or a priest visited patients who might have spiritual needs. Although Anita felt no particular need to see them, she thought it would have been good for patients' spiritual well-being to have them around, especially when patients were undergoing difficulties.

Based on the experiences shared by Filipino-Canadian patients, faith seemed to play a vital part in their lives. Lito, for example, who had a severe heart attack 6 years earlier, considered waking up from his state of unconsciousness after 3 weeks as a miracle; "Everybody thought I would die. It is a miracle I woke up. I thanked God that I am still alive and kicking." He noted that everyone had thought that he would die, and he considered his regaining consciousness a "miracle." He also realized how fortunate he was to be in Canada. He claimed that if he had been in the Philippines when he had his heart attack, he would have died. His wife explained that the doctors and the nurses were determined: They did not easily give up on him. The two CAT scans showed that he had had internal bleeding twice in 3 weeks. The clot they saw was deep-seated. The doctors informed Laura that they had done the best they could and that there was nothing more they could do for her husband. Therefore, when the doctor advised her to call her relatives and do whatever they had to do

because they could not get any response from him, she immediately called a Catholic monsignor from Calgary to anoint him with the sacrament for the sick while he was in the ICU:

> Although it took long, almost 3 weeks, and it was no longer...that was why the doctor said...he asked the two kids to go out of the room, there was only me and his cousin [name of the cousin]. He said, "we did our best." So when we called Msgr. They phoned from Calgary, Msgr.

His family and relatives were all gathered around him in the ICU, where they do not usually allow more than two visitors at a time. His wife recalled one nurse who advised her to get a second opinion:

> There was one nurse who said to me that it is worth asking for a second opinion. They said sometimes the doctors may be wrong. So we are just living in faith. Were it not for God's mercy [*awa nang Diyos*] maybe he would have been dead. We will not be forsaken. Always even in the Philippines, we have a devotion to our Sorrowful Mother [*Dolorosa*]. It was indeed a miracle to find that he regained back everything.

Many Filipinos are devoted to Mary, the mother of Jesus, or to other saints. They honor and give homage and respect to them, and ask that they intercede on their behalf. Like faith, prayer was also an integral part of their lives. They believe that miracles are answers to their prayers. This was evident in Omar's experience as he grappled with the fact that his wife was dying of cancer. He vividly remembered her distressed condition as a cancer patient. She could not speak, eat, drink, or sleep. Their daughter, who is a nurse, knew that there was a slim chance that she would live longer but did not tell him for fear of raising his hopes. However, on his way to visit his wife, he met one of the doctors. He asked her how his wife was and if there was any hope for her. "Well, as the doctor told us, only a miracle from heaven can save your wife." His wife was examined by a number of doctors, but they all said there

was no hope. Omar had second thoughts: "I don't believe what the doctor says. I believe in God. God gave us life and God has the right to take back our life."

He thought that his wife became ill because she was homesick and that she was affected severely by their son's death in the Philippines. He also noted that her loneliness became worse because she was always alone at home after he and their children left for work and their grandchildren left for school. She had been diagnosed with lymphoma. Her condition worsened:

> What I did when I reached home was to gather all my children and I lead the prayer. We prayed everyday then one day, there was a Filipino-Chinese who came to visit her in the hospital and brought a miracle water. She said, "I do not know her." I was supposed to arrive in the afternoon but it was really very cold. It was very very cold. I said, "Who are you by the way?" "I am a friend of one of your children." She said, "She is already seriously ill?" Yes it is true. It is already three days she has not eaten anything. She said, "I have one bottle of miracle water from France. It was brought back to us by my uncle." There was one man who was sick like my wife, he is still alive until now. She might have been God sent because of our prayer. Monday, she made a motion to the nurse that she wanted water. I opened the bottle, I made her drink it. She drunk and then the following day, Tuesday, I went back. [She] drunk [and] drunk until, afternoon, the water was consumed. On Wednesday, I came back, she was able to speak already. It was the only thing that cured her.

Two years later, she was diagnosed with a brain tumor. The doctor advised surgery or radiation therapy. She agreed to try the radiation therapy and chemotherapy:

> I requested for prayers from the Missionary of Legion of Mary who were in United States. I sent a donation. I made a long distance [call] to my children and asked them to include her intentions in their rosary or in their prayers. I donated 2,000 pesos for our devotion to the Senior San Roque in our barrio [village] and then in Bohol for our devotion to Senior San Antonio and in our village where I was born, I donated 2,000. And in the place of my wife I donated 1,000 for prayers. Many prayed. With God's mercy [*sa awa nang Diyos*] my wife is alive. She lived because of the prayer and when she was back, we went to [the Philippines] in 1986 we went to the United States ah in California because she has many relatives there and we visited there. In 1987, we went home to the Philippines to visit.

He attributed his wife's cure to the prayers.

This strong faith in God and prayers was also manifested in Florence, a grateful mother who waited and prayed for 11 years and was blessed with two miracle

babies. She described her experience as long, tedious, and painful, but rewarding, after the numerous frustrations she and her husband went through. The experience was painful, because she and her husband had to subject themselves to numerous operations, D & Cs, in vitro helping drugs, laparoscopies, and diverse laboratory tests. Every time they went through a certain procedure, they hoped that she was pregnant but discovered that she was not. Moreover, no one was able to tell her why she was unable to become pregnant:

> It's like a roller coaster ride. There are highs and lows and IVF amplifies that. Your highs will be so high, you know, finding out you are pregnant and then the lows would be the ebb because it is just the worst thing to lose the baby you have been wanting for so much. We had to go through that because we don't want to regret in our old age that we didn't try. So we exhausted everything and if we didn't have a baby then that's fine because we tried everything we did. You know, we didn't leave any stone unturned.

In her interview, she called both of them her "miracle babies," because the probability at that time of taking home a baby following such a procedure was only 15%. She explained further that once they reached the stage where they really wanted to have children, they were willing to do anything. When asked what it was like to have those two miracle babies, she said,

> It was, you know, ecstatic...it was just the most powerful thing. My doctor came out of the operating room and gave the baby to my husband and he said Happy Anniversary [laughing]. He knew the song. It is kind of exciting and, you know, we cried, we both cried. You know what? We've been waiting for and praying for eleven years.

"Miracle" is the word that Florence used to describe what she and her husband had been waiting for and praying about for 11 years. Filipinos consider things that happen in their lives that are out of the ordinary as miracles and count them as blessings. They also consider an unforeseen event a miracle.

For some time, Florence and her husband had been faced with the dilemma of what to do with the six remaining embryos stored for them. Florence had been

married at the age of 25, and had had their first baby at 36 and their second at 38. She wanted to try again at 41, but with the postpregnancy complications she had had with her second baby, her doctor said, "You have two beautiful children, a boy and a girl…no more. People would stop at that [laughing]. Why would you want to risk your life?" She mentioned praying repeatedly on this matter, because she always wanted to have more children. However, at her age, she realized that perhaps not to have more children was the best decision. It occurred to her that she might have a third one, but if she died, her children would become orphans and her husband a widower.

In addition to the emotional roller coaster she described earlier, Florence also went through what she called a spiritual struggle. Being a Catholic, she knew that the Catholic Church does not accept in vitro fertilization (IVF), but a question lingered in her mind: "Why did God provide us with this procedure if we could not avail of this, which was the only chance to have a baby?" She and her husband decided to ask a priest, and they were told that the decision was a personal one. The only reason the Catholic Church was against IVF was the uncertainty concerning what the couple would do with the spare embryos. There was, of course, the option of keeping them frozen indefinitely, which they had done so far. Another option was donating them for research, which was something she could not do because of all she heard about embryos' being destroyed or discarded. A third option was to donate them to an adopting couple so that they could implant the embryos.

> I prayed about all this because it is very hard for me. I wanted to carry the remaining embryos myself but basically it is just too risky for myself and for my family. In the beginning, I was not sure, but one night I went to check on the kids while they were sleeping. I was looking at them and they look so lovely and so angelic and I said, "You made my life complete." I was just so

> filled with happiness and emotion and I said "Oh, thank you God for giving me this miracle" and then something in my mind said and maybe the Holy Spirit was guiding me, "Why don't you make another couple's life complete." And that's when I got my answer. I am going to donate them to someone who's been trying to have a baby.
>
> I was at peace, and when I woke up the next morning, I told my husband about it. At first he wasn't, you know, it was just like having your baby adopted, right, but it was hard for him too. Finally one night he said, "You know what, I've been thinking about that, I think it is the best decision we could do." So we are in that process now of drafting the contract. Some friends asked me what if we gave them to the wrong couples and this and that...I said, "God will give those babies the perfect parents." I have faith in God that he will give those babies the perfect parents. People who go through the IVF would love to have babies and they just could not. So these are parents who would welcome my babies in their own lives.

Faith played a vital role in their decision to maintain and save human life. The couple could not bear the thought of destroying the embryos because for them doing so was murder. Therefore, every year they paid Canadian $300 in storage fee. The mother explained further:

> It's a sin. That's life. If I think of my two kids, they were frozen embryos. There's life in those frozen embryos so to destroy them is murder for me. Donating it for research is not an option either because they are going to destroy the embryos too and get the stem cell, right? So those two are not my options. It all depends on how and when you believe life begins. I want to give those embryos the chance to live. I just don't want to keep them frozen there until we die because when we die they will destroy it. So we have to do something with it.

She talked about the reunion of the first 1,000 IVF babies and found herself in shock when she learned about a Thai couple that had decided to destroy their 10 remaining embryos. She noted that they were not Christians. For them, the embryos did not have life, but for many Filipinos, who have a strong Catholic background, it would be difficult to make the same choice. For most of them, life begins at conception.

> One Filipino couple, who is deeply Catholic as well, had been struggling spiritually. I told them that I am deeply Catholic too, but I am at peace with my decision and now I have two wonderful kids. Another couple will be having two or more wonderful kids too because of their decision to go through IVF. So I guess it all depends on how at peace couples are with their decision. I know of another couple who went through IVF. They had a twin who just turned one in August so it is just wonderful. Yeah, well it is with the grace of God and by the grace of God. It is a day to day thing. Every day

> there are miracles happening. People wait for big miracles but each day is a miracle. We prayed and we prayed about all these.

Filipinos value life in general. They would maintain and save life at all cost. A mother, for example, who had been diagnosed as having mitral valve stenosis discovered that she was pregnant again soon after delivering her first baby and yet opted to carry the baby to term in spite of the risk to her life. The health professionals in the hospital asked her if she wanted an abortion, and her reply was, "Sorry, it is already there. I might as well carry the baby." She was happy to have two beautiful daughters, and never for a moment regretted the decision she made to carry her second baby to term.

Summary

In summary, Filipino-Canadian patients and their families expressed spiritual needs while in the hospital. Family members and relatives were usually expected to ensure that spiritual care was provided to them. The two mothers quoted above have different circumstances, but both evidently put great value on human life at the risk of their own lives. The spiritual struggle described by Filipino patients reflected how deep their faith was and how it directed their decisions. It also showed how prayer permeated every dimension of their lives.

CHAPTER 6

DISCUSSION

The results of this study generally support Orque's (1983) findings, which reflect the personalistic worldview of Filipinos, a worldview that fosters intimacy, warmth, security of kinship, and friendship in all their interactions. The findings, as Vance (1995) also noted, confirm that the family is still the basic unit of social organization; immediate family members provide the most support, especially during illness or crucial moments in their lives (e.g., births or deaths).

Although Santiago (1976) examined five behaviorally recognizable levels of interaction under the two categories of "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) in the food-sharing activities among the Filipino middle class in the province of Bulacan, I am the first to explore these levels of interaction and the two categories in the patient-nurse relationships.

Discussion on the Findings

Type of Patient-Nurse Relationships

To understand better these levels of interaction as evidenced in the experiences of the Filipino-Canadian patients and their relationship with nurses from other cultures, I constructed a scheme following Morse's (1991) model of nurse-patient relationships, which identified four broad types of mutual relationship. Morse's model is shown in Figure 1. Morse described these relationships, in ascending order of involvement and intensity, as clinical, therapeutic, connected, and over-involved. She found that these different types of relationships depended on certain circumstances, such as the length of time the nurse and the patient spend

Figure 1: Morse's (1991) Types and Characteristics of Nurse-Patient Relationships.

Characteristic	Types of Relationship			
	Clinical	Therapeutic	Connected	Over-involved
Time	Short/transitory →	Short/average →	Lengthy →	Long-term →
Interaction	Perfunctory/rote →	Professional →	Intensive/close →	Intensive/intimate →
Patient's needs	Minor Treatment-oriented →	Needs met Minor-moderate →	Extensive/crisis "Goes the extra mile" →	Enormous needs →
Patient's trust	Nurse's competence →	Nurse's competence Tests trustworthiness →	Nurse's competence and confides Consults on treatment decisions →	Complete: "put their live in the nurse's hands" →
Nurse's perspective of patient; patient's perspective of own role	Only in patient role →	First: in patient role Second: as a person →	First: as a person Second: in patient role →	Only as a person →
Nursing Commitment	Professional Commitment	Professional Commitment Patient's concerns secondary	Patient's concerns primary Treatment concerns secondary	Committed to patient only as a person Treatment goals discarded

together, the needs and desires of the nurse and the patient, and the presence or absence of trust between the patient and the nurse. In addition, she compared the effects of nurses' perspectives of the patient and the patients' perspective of their roles, the nursing commitment, and personality factors.

It is important to note that although there is a clear distinction between "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) relationships in the stories of their experiences while in hospital, Filipino-Canadian patients who participated in my study paid no particular attention to determining what levels of interaction they had with the nurses, except for the few who stayed in the hospital for a long time and had the opportunity to establish a nurse-patient relationship that may have progressed through the levels of interaction.

Miranda, McBride, and Spangler (1998) claimed that the insider/outsider distinction may be less important in Filipino families and communities, especially among recent immigrants. However, the "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) delineation emerged very distinctively in my study of Filipino-Canadian patients who immigrated to Canada in the same time frame as the third-wave Filipino Americans (1960 to the present). These two categories permeated the Filipino-Canadian patients' prerogative of who performs the tasks or who receives information that they considered "personal" and "private."

The Filipino-Canadian patients realized that the quality of interaction and the depth of relationship developed between the nurse and the patient is influenced by the following factors: (a) length of stay in the hospital after the retrenchment years, (b) urgency of the patients' conditions, and (c) the intimacy required in doing most

nursing care procedures. The shorter period of hospitalization placed most Filipino-Canadian patients in a situation where they had to consider almost immediately whether individuals who cared for them were either "not one of us" (*ibang tao*) or "one of us" (*hindi ibang tao*). There were situations wherein Filipino-Canadian patients felt they had little choice but to interact without having gone through the initial levels of formality (*pakikitungo*), adjusting (*pakikibagay*), and acceptance (*pakikisama*) under the "not one of us" (*ibang tao*) category. During emergency situations, for instance, they found themselves in the subsequent levels of mutual comfort (*pakikipagpalagayang-loob*) and/or oneness (*pakikiisa*) under the "one of us" (*hindi ibang tao*) category or not in any level at all. This means that the nurse-patient relationship has remained unilateral.

Unilateral is a term used by Morse (1991) to describe the asynchronous relationship between a nurse and patient. This is evident when one of them is unwilling or unable to develop the relationship to the level desired by the other. Findings of this study confirm Morse's observation that the nurse-patient relationship has little to do with technical competence. Morse's construct indicated that time; the nature of interaction; the patients' needs, willingness to trust, and perspective on their own role; and the nurses' commitment and perspective on the patient were key to achieving the four main types of mutual relationship in ascending order of involvement and intensity. When these occur, however, both nurse and patient experience synchrony in their relationship.

In the Filipino-Canadian context, the levels of interaction are listed and categorized under the two types of relationship, namely, "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*), in Figure 2. The Pilipino terms used by Santiango (1976) in his study of food sharing social interaction remained the same in this study and except for

"oneness," all other English translation were changed according to how best they fit the description of the Filipino-Canadian patients' experiences.

In addition to the nature of interaction, each level of patient-nurse interaction is characterized according to certain facets in the relationship, such as the nature of patient-nurse interaction, the patient's openness in expressing his or her needs and feelings, the patient's willingness to trust the nurse, and the patient's response to nursing care. Other contextual factors were also identified such as type of unit, urgency of the patient's condition, length of stay in the hospital, presence of families, and class issues that the Filipino-Canadian patients expressed as affecting the quality and depth of the relationship. Findings of this study also showed that the nurse-patient interaction may either progress or regress in any of these levels of interaction as they may also shift between the "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) realationship. To add insight into these levels of interactions, I will refer to concrete examples derived from follow-up interviews concerning situations already cited in Chapters 4 or 5. These examples illustrate the extent to which facets of these interaction come into play in the experiences of Filipino-Canadian patients, and I compare and contrast them in Figure 1 with the type of relationships described in Morse's (1991) models of nurse-patient relationship.

Levels of Patient-Nurse Interaction

Initial interviews conducted among Filipino-Canadian patients indicated that, based on their social organization, two prominent types of relationship emerged in their social interactions—the "one of us" (*hindi ibang tao*) and the "not one of us" (*ibang tao*). Follow-up interviews showed that the levels of the interaction between the nurses and the

Figure 2: Types of Relationship and Levels of Patient-Nurse Interaction and Their Characteristics.

	Type of Patient*-Nurse Relationship				
	Not One of Us (*Ibang Tao*)				One of Us (*Hindi Ibang Tao*)
	Levels of Patient-Nurse Interaction				
	Level of Formalities *Pakikitungo*	Level of Adjusting *Pakikibagay*	Level of Acceptance *Pakikisama*	Level of Mutual Comfort *Pakikipagpalagayang-loob*	Level of Oneness *Pakikiisa**
Characteristics					
Nature of Interaction	Polite, formal May be cordial	May nod or say "yes" but not necessarily agree	Agree and will "go along with"	Sympathetic with each other	Identify with each other
Patient's Needs	Concealed	Concealed	Articulated through family/relatives	Articulated directly to the nurse	Anticipated by the nurse
Patient's Feelings	Concealed	Concealed	Confided only to family/relatives	Revealed	Open
Patient's Trust	Tested	Conditional	Initially given	Mutual	Complete
Patient's Response to nursing care	Silent and Reserve	May express agreement to care but not comply	Agree to care and willingly comply	Entrust one's self in the care of the nurse	Patient and Nurse share care goals

* Patient in the Filipino context refers to the entire family including extended family.
** Santiago (1976) labeled this category "level of oneness."

patients do not necessarily follow in the manner described by Santiago and Enrique (1976). Many of them recognize that there are certain levels that they go through, but they cannot identify when each level begins or ends because of their experience of being cared for by nurses regardless of whether they came from the same culture or from other cultures. Although Filipino-Canadian patients do not consciously go through these levels and the levels do not always happen sequentially, a progression in these levels of interaction has been evident. There were situations where Filipino-Canadian patients had no choice but to entrust themselves and their lives to the nurses and therefore had to go through the initial levels of interactions at a later stage of their stay in the hospital, when they are no longer in critical condition.

It was also evident that although "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) relationships predominate among Filipino-Canadian social interaction, these do not necessarily determine the levels of nurse-patient interaction. It is the *kapwa* worldview, however, that overrides all kinds of relationship and levels of interactions. Florence, for example, said,

> No, it was not really that they were not "one of us" but because we come from the same culture we could communicate and then one of those two nurses had a similar difficult pregnancy experience as mine hence it was easy for her to relate with me and I can relate with her as well. Her baby was as small as mine and things like that. So in that way maybe between those two nurses who took care of me I could relate more with the other one. I still see her once in a while.

It is, therefore, the *kapwa* worldview that evidently determines the type of elationship—"one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*)—and the levels of interactions—formality (*pakikitungo*), adjusting (pakikibagay), acceptance (*pakikisama*), mutual comfort (*pakikipagpalagayang-loob*), and oneness (*pakikiisa*).

"Not One of Us" (Ibang Tao)

Level of Formality (Pakikitungo)

A degree of formality often exists in the initial contact between the patient and the nurse. Both the nurse and the patient are cordial, and their interactions are polite and formal. Paula gave an example of how a White worker would greet her with a "Hi!" and compared this with the indifference of a Filipino worker who served her a tray of food. This was rather unusual, but *pakikitungo* is a level characterized by superficiality. In addition, the patients' responses might be reserved. If the patient's condition is not serious, then these initial contacts may be brief, and the patients will likely conceal their needs and feelings. However, if the patients are in serious condition requiring a long hospital stay, then they may test whether the nurses can be trusted. Attempting to establish a trusting relationship is crucial at this stage. However, because there is little emotional involvement and due to the seriousness of the patients' condition, they might not even bother to learn the nurses' names. The example that best illustrates this level of formality (*pakikitungo*) is Karen's experience with the Black nurse and the White nurse when she was admitted to the geriatric unit.

Karen's experience with the Black nurse is typical of what Morse (1991) referred to as "unilateral" (p.456), in which the nurse was unwilling or unable to develop the relationship to the level desired by the patient. It is also possible that the Black nurse resorted to coercive or manipulative behavior to try to entice Karen to become more involved or independent. However, Karen felt the nurse was not being nice to her and described her as harsh and rough. On the other hand, Karen's account of her experience with the White nurse, whom she described as "really nice,"

revealed many of the characteristics of the first two levels: formality (*pakikitungo*) and adjusting (*pakikibagay*) in Figure 2.

Level of Adjusting (Pakikibagay)

At the level of adjusting (*pakikibagay*), Filipino-Canadian patients may be ambivalent about trusting the nurse. Trusting was a real challenge, especially for those who had an unpleasant experience in the past because of an initial distrust or mistrust on the part of the patients. The willingness of the patients to trust is, therefore, very conditional. However, if the patient's previous experience was pleasant, adjusting (*pakikibagay*) is the level at which the patient adjusts his or her expectations, according to what the nurse is able to offer. Patients may nod their heads or say "yes" but not necessarily agree with the nurse. Generally, they will express agreement but will not comply with the nurse. They might still be reluctant to express their needs and conceal their feelings from the nurses and may have to depend solely on family members and friends for psychosocial support. An example of *pakikibagay* (level of adjusting) is Carla's account of how the nurse from the same culture was accommodating, and showed interest and concern by asking questions such as "How are you feeling?" "Do you need anything?" "Are you comfortable?" "Do you need help?" and "Do you need help to go to the bathroom?"

Level of Acceptance (Pakikisama)

Level of acceptance is generally characterized by the patient's conformity. This level pertains to the cultural value of *pakikisama*, described in the literature as "going along with." Patients agree and are willing to go along with whatever the nurse says. Their needs are articulated through family members and relatives, but their feelings are still concealed from the nurse. The patient may initially trust the

nurse and comply with the treatment. This is the highest level a patient can reach in interacting with nurses whom they consider "not one of us" (*ibang tao*). Thomas affirmed that *pakikisama* is developed in the long run, especially in patients who spent longer periods of time with the nurses in the room or unit:

> Everyday, you see each other if not everyday at least every other day you get to see each other. You develop this level of acceptance [*pakikisama*] with them and you become comfortable [*nagiging palagay ang loob*] with them that is my experience even to this day I feel like I have known them for a long time or they are like old friends. Yes, when I go for my check-up and follow-up therapy. We greet each other with a very warm welcome. We treat each other very much like brothers and sisters.

Level of adjusting (*pakikibagay*) and level of acceptance (*pakikisama*) approximate Morse's (1991) "clinical" relationship, where the patient is satisfied with the care provided. She described the patient as having no expectations of the nurse beyond the care required and received. The nurse is able and willing to meet those needs quickly and efficiently as a professional. As in the "clinical" relationship, these two levels, which are under the "not one of us" (*ibang tao*) category, exhibit a superficial and courteous interaction between the nurse and the patient. Thomas recalled that in the beginning he did not immediately feel comfortable:

> I have to adjust [*nakikibagay*]first to go along [n*akikisama*] of course. I observe or get to know [*pinag-aaralan*] the nurse first. I have to find out if the nurse is meticulous [*maselan*] or conceited [*suplada*] or kind [*mabait*] or whatever, don't you? These nurses are not the same. So I did not immediately feel comfortable [*palagay*] but once you see that the nurse is very approachable, smiles and does not get angry when you call that is the only time I feel comfortable [*napapalagay ang loob*]; but I was not comfortable with all the nurse. Of course there were many nurses who took care of me. They always change every time there was a new shift. I did not feel comfortable [*palagay ang loob*] with all the nurses. I also had a variety of experiences with different nurses.

Morse (1991) described this stage in the nurse-patient interaction when the patients try to "test the waters" (p. 458). If they are not satisfied, then no further expectations

are made. Thomas cited an example from his hospital experience to illustrate these dynamics:

> When my request is not immediately addressed or sometime it is even forgotten especially towards the end of their shift of course I do not know when their shift is over but that is when my request is likely to be ignored. Eh I just tell the next nurse that I made such a request to whoever it may be. "Ah her shift is over, she is gone." In that case I remind the nurse in the next shift. So from that point I remember that particular nurse who is not so approachable. So even if I'd like to say some thing to her or if I'd like to ask her eh I'd rather not. She can just do whatever she would like to do whether it was to give the medicine or whatever it was she has to do to me.

When Thomas perceived that the nurse disregarded his request, he decided at that point that the nurse would remain as "not one of us" (*ibang tao*). Nothing more is expected beyond the care required and received. No effort is made to go farther in the spectrum of interaction. However, if the nurse responded positively, then the interaction escalated to the next level of interaction—level of mutual comfort (*pakikipagpalagayan nang loob*) and possibly the level of oneness (*pakikiisa*)—and perhaps transcended the boundaries of "not one of us" (*ibang tao*) to becoming "one of us" (*hindi ibang tao*).

One of Us (Hindi Ibang Tao)

Level of Mutual Comfort (Pakikipagpalagayang-loob)

Once the Filipino-Canadian patient determines that the nurse is "one of us" (*hindi ibang tao*), his or her level of comfort increases. This interaction is characterized by the sympathetic relationship established between the patient and the nurse. The patient is comfortable in expressing agreement or disagreement with the nurse and articulates his or her needs directly to the nurse. *Palagay ang loob* means entrusting one's inner self to someone. There is mutual trust evident between the patient and the nurse; the patient is therefore willing to expose his or her feelings and

may even be more spontaneous in expressing those personal feelings. Thomas, for example, showed how he trusted the nurses and their competent care:

> They were really professional. I know how careful they were in whatever they were doing especially in giving me the blood transfusion. It was not only one nurse who checked it. There were two nurses all the time. The second nurse always made sure that what was being transfused to me was the right blood. They were really careful about those things, even in administering the medicines. They never forget those. They closely monitor and make sure they always do the follow-up.

Florence found herself comfortable almost immediately with the nurses: "For me I adjust so fast because it is easy for me to adjust." She teasingly added that she was *walang hiya* (shameless). She explained that people differ and that one's ability to adjust and to be comfortable depends on one's nature. When asked to explain what she meant when she described herself as being *walang hiya*, she said,

> [Laughing] No, I am just joking. I am open and honest. I mean...I do not hide anything. Hmm. Even with the White I can be open [laughing]. Even the... actually there are White nurses there whom I was comfortable with [*nakapalagay nang loob*] but of course the level is deeper with Filipino because ...isn't it different? Eh of course you can relate better. We have distinct characteristic that allows us to relate with each other. Isn't it?
>
> Me, I cannot really pin point. No, no. I can not pin point at this point but the mere fact I can easily feel comfortable [*mapalagay*] with the nurses from the same culture because I know that she will easily understand [*maiintindihan*] me whereas if it were a White nurse she probably will not immediately understand the weird things in our culture, don't you think so?
>
> My relationship with the Filipino nurse was deeper because, first of all, I stayed in the hospital for months. When I delivered my second baby it was a matter of weeks perhaps one week. That is why I can remember my relationship with that Filipino nurse more than the Black nurse.

When asked whether accommodating the patients' needs made the Filipino nurse go out of her way and thus become over-involved with her patients, she said, "Ah, no she did not do anything like that. No, well it is only during the break time when she comes to my room to chat or tell stories with me. Ah no, she was not like that at all." Florence did not think that nurses from the same culture would become over-involved

because "they are professional and they deal with patients professionally. They know their limits."

Level of mutual comfort (*Pakikipagpalagayang-loob*) is equivalent to Morse's (1991) "therapeutic" nurse-patient relationship, whereby the patient's psychosocial needs that must be addressed by the nurse are usually routine. Morse explained that in this type of relationship, the nurse views the patient first within the patient role and second as a person with a life outside the hospital context. Both the patient and the nurse "test the waters" early on in the relationship. However, in this level of mutual comfort (*pakikipagpalagayang-loob*), the patient has gone beyond "testing the waters." The preliminary trials in the (level of adjusting) *pakikibagay* and (level of acceptance) *pakikisama* have passed the conditional phase, and the patient has developed a feeling of security and confidence that the nurse will take care of him or her. In other words, both patient and nurse have reached the comfort zone in their relationship.

Level of Oneness (Pakikiisa)

In level of oneness (*pakikiisa*), the patient feels that the nurse is able to identify with him or her, hence the oneness between them. Agreement and disagreement are freely shared with each other to an extent that the patient's needs are anticipated by the nurse. This level is the same as the "connected" relationship in Morse's (1991) model, where the nurse sees the patient primarily as a person and second as a patient even while maintaining a professional perspective.

Karen reiterated that as the days went by and she came to know the nurse, there was some sort of mutuality—*kasunduan*, or a reciprocity—established between her and the nurse:

> You feel comfortable. Yes you have just laid an eye [*nakitamo palang*] on the nurse, you are already happy to see the nurse. Then you feel comfortable to talk to her about your feelings...about...if you are asked, "how do you feel about this? If you are comfortable with the nurse...in that level where there is mutual respect you will say how you exactly feel but there are times when it depends on the reaction of the nurse you would not want to say anything.
>
> I've gone through that [hahaha]. That is why when I was there in the *kuwan* eh I was there with the psychiatry in [name of the hospital] it took three months before I could share what it was I was feeling what was causing my depression. And then I told them I am a very personal person I am very...I am not comfortable talking to people what is in my...what I actually feel. I have not done any sharing with anybody except members of my family. There are things I can not share...not even with members of my family. I keep it there, only when I feel comfortable or until I am able to respect the person. It took them three months. They just kept encouraging me.
>
> I did not want to open up because I feel that it is something very personal but finally they were able to convince me in the third month. I am a very good listener but to share your personal feelings, I have never really done that before. You go deep into your personal feelings to find out what is causing the depression. I have never done that before but they were able to help me.

This depression happened long after the hospitalization she described to me during the initial interview. It occurred only 6 months before the interview, as a result of the many medications she was taking. She said she was still undergoing therapy to help her overcome her depression. When asked whether she went through the initial levels of formalities (*pakikitungo*), adjusting (*pakikibagay*), and acceptance (*pakikisama*), or whether she immediately felt comfortable with the nurses, she explained,

> Yes, as far as I am concerned, you are not suppose to get yourself [*ano*] [immediately comfortable] when you have just known [*kakikilala*] the person. It always takes time. Yes. Maybe if the patient has been in the [hospital] for some time probably after three days, you can already...[determine] if you can trust the nurse, if you like her a little bit at that time but not all of a sudden when the nurse enters. Of course we always go through some trial and error to consider yes isn't it [laughing] you know that [laughing].
>
> But there are nurses from the very first moment you [*ano*] encounter them, you already fell good inside [*maganda na ang kalooban*]. Because of the way the nurse looks, or just from her face eh her smile and then how she talks to the patient all those thing, with respect yes that way and then the nurse will ask and say something like..."O how do you feel? What do you need?" things like that. There are a lot who are like that eh nurses eh personal touch is very important like you.

Because there is full trust between the patient and the nurse, the patient is willing and able to disclose his or her feelings without embarrassment. At this level, the patient and the nurse share care goals and work harmoniously together to achieve them. The patient is free to consult the nurse about doubts or may even seek the nurse's advice or recommendations concerning aspects of his or her treatment or nursing care.

Florence's interaction with the two Filipino nurses and the other nurses who took care of her during her first hospitalization was another example where a personal touch was evident. She and the nurses were together long enough for the relationship to have evolved beyond a clinical and therapeutic relationship. In the case of the two Filipino nurses, the process was accelerated because they were of the same culture; therefore, they could identify with and fully understand her, and so were able to anticipate her needs. The nurses were willing to enter the relationship and go an "extra mile" (Morse, 1991, p. 458) in accommodating Florence and her husband's needs, such as providing pillows when he slept in the hospital during the weekend. Florence even recalled being able to share jokes with them in Pilipino, demonstrating the ability of the nurses to identify with the patient as a *kapwa-Filipino*, to connect in the same language and cultural context, and to share the difficult pregnancy experience.

The two levels under the "one of us" (*hindi ibang tao*) category exhibit characteristics of Morse's (1991) "connected" relationship. She explained that the nurses who reach this relationship with their patients might even serve as advocates, interceding on behalf of the patient with family or medical staff, and buffer or protect the patient from unpleasant aspects of care.

The findings of this study showed that the patients' trust determines whether the nurses from the same or other cultures are "one of us" or "not one of us." The levels in the extreme right of the continuum of interaction (see Figure 2) under the "one of us" (*hindi ibang tao*) category indicate the level of trust there is in an interaction. Santiago and Enriquez (1976) translated and described these last two levels of interaction as follows:

Pakikipagpalagayang-loob (level of mutual trust) "being in rapport/ understanding/acceptance of"

Pakikiisa (level of fusion, oneness and full trust) "being one with"

In many hospital situations, because of the urgency of the patient's condition and the intimacy required in doing most nursing care procedures, both the patient and the nurse are immediately placed in a situation where they have no choice but to interact without going through the levels in the extreme left of the continuum of interaction under the "not one of us" (*ibang tao*). These three levels resembles the three levels labeled and described by Santiago and Enriquez (1976):

Pakikitungo (level of amenities) transaction/civility with

Pakikibagay (conforming) interaction with

Pakikisama (adjusting) in conformity with/ in accord with

For Donna, it really did not matter whether the nurses were "not one of us" (*ibang tao*) or "one of us" (*hindi ibang tao*):

> I don't think that is the point. My experience with nurses, as a general rule? Yeah many of them were kinder yeah. There were a lot of them who were kinder. All the nurses are good and kind except for that one so it has nothing to do whether I know them or not because I did not know all of them. I did not know anyone.

> But after the initial because my condition was like emergency. I was somehow critical the first few days and then when I was settled then the nurses became relaxed as well with me because I was no longer as seriously ill and the time and the attention they gave me became lesser than before in the beginning.

She claimed to have established a certain degree of relationship but accepted that none of these relationships went any deeper than the level they were during the initial contact. She therefore did not have the opportunity to develop the relationships, nor did the nurses and she have further interaction. And all these transpired a little more than 2 weeks:

> And I was a bit relieved *nakahinga* that my condition was no longer in a critical stage and so when I was getting better perhaps their attention was now devoted to other patients who needed more care and time.

When asked whether she immediately felt comfortable (*napalagay ang loob mo*) with the nurses, she agreed that a certain involvement was needed:

> Yeah with other nurses yes. I think it help that you are...when they are accepting...when they seem kind to you it helps of course rather than being somewhat detached. Yeah yeah of course. Their concerned attitude...no I mean concern. Their attitude should be concerned...they're concerned for you. I mean thoughtful. When you have needs, they really come immediately to attend to your needs. Unlike the other nurses who come only when they have the time and they seem irritated [*inis*] in doing things for you. Yeah, I can perceive it definitely. I think everybody would because it seems they were doing it just like a job. Kindness is really number one. That and also the caring attitude. Yeah. Because for people who are sick that is the most important thing isn't it? To be cared for because if you are sick then you need that.

Filipino-Canadian patients, however, are able to "sense intuitively" (*pakiramdam*) if the nurses who took care of them are "one with them" (*may pakikiisa*). *Pakikiisa* is the total sense of identification, equivalent to the cultural concept *pakikipagkawa*, which most participants referred to in describing how nurses who were "not one of us" (*ibang tao*) became "one of us" (*hindi ibang tao*) despite the brevity of the encounter in the hospital. This shows that the core value of *kapwa* is

the superordinate concept of all relationships. It encompasses both categories of "not one of us" (*ibang tao*) and "one of us" (*hindi ibang tao*), just as *pakikipagkapwa* embraces all the levels in both categories (Enriquez, 1976).

Just as the concept of *kapwa* is a distinct contribution to the field of social psychology, the concepts "watching over" (*bantay*) and "caring for" (*alaga*) are distinct contributions to the field of nursing. Because nowhere in the transcultural nursing literature has anyone written about these two concepts, I have devoted the whole of chapter 5 to these two Filipino cultural concepts, and the link between them and the two categories "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) as applied to the three dimensions of nursing care.

In chapter 5, I also discuss the importance of nurses both from the same culture and from other cultures being able to switch from one category to the other and its implications in improving the quality of care given to Filipino-Canadian patients. It is important for nurses to know that although Filipino-Canadians still uphold strong family ties, as demonstrated by these categories, this does not mean that they cannot accommodate people who are not family members or who are from other cultures.

Findings of my study also showed that regardless of whether a nurse is from the same or from other cultures, Filipino-Canadian patients consider them "one of us" (*hindi ibang tao*) if they possess qualities such as kindness, respectfulness, courteousness, approachability, and willingness to accommodate the needs of the patients. All of these qualities are essential if one is to achieve the levels of formality (*pakikitungo*), adjusting (*pakikibagay*), and acceptance (*pakikisama*) that are under

the category "not one of us" (*ibang tao*). These qualities, therefore, are prerequisites to the level of mutual comfort (*pakikipagpalagayang-loob)* and oneness (*pakikiisa)* under the category of "one of us" (*hindi ibang tao*). In other words, nurses qualify as "one of us" (*hindi ibang tao*) if Filipino-Canadian patients find them kind, respectful, courteous, approachable, accommodating, and trustworthy. Because these characteristics are highly valued among Filipino-Canadians, it is important for nurses and other health professionals to be aware of them to improve the quality of patient-nurse interactions and the depth of patient-nurse relationships.

In a recent article, Dreher and MacNaughton (2002) maintained that it is in the clinical level where the expectation for cultural competence was the greatest and where it was least likely to be useful. The heterogeneity found among the Filipino people supports their contention that although individuals belong to the same cultural group, they do not necessarily respond in the same way at the individual level. What Dreher and MacNaughton argue, therefore, concerning the cultural and population variable was consistent with my research and is most relevant at the individual level where care takes place and is crucial if nurses are to make a difference in the way they provide care to culturally diverse patients.

Contribution to Literature

Culturally Competent Nursing Care

The findings of this study contradict statements pointed out in the review of literature by authors like Leininger (1977) and McGee (1992), who contend that many manifestations of human behavior are determined by culture and therefore insist that nurses need to be sensitive to and knowledgeable about the culture of their

patients to provide individualized and effective care. Behaviors identified by Filipino-Canadian paitents such as kindness, respect, approachability, willingness to accommodate, continuity, common experience, trust, and personal disclosure are not necessarily culturally determined, directed, and controlled. These are attitudes and behaviors nurses must learn and acquire regardless of their cultural background. The experiences of Filipino-Canadian patients also highlighted a number of contextual variables, such as the urgency of their condition, type of unit, presence of family, and class issues, that might affect the depth and the quality of their relationship with the nurses and other health professionals.

Culture-specific Nursing Care

After having conducted this study and successfully demonstrated that the cultural values of inclusion and exclusion are of great importance to Filipino-Canadian patients who participated in this study, there are questions that continue to haunts me. How appropriate was it for Orque (1983), Vance (1995), and Leininger (1995) to apply the so-called Filipino cultural values of losing face shame (*hiya*), saving face or self-esteem (*amor propio*), debt of prime obligation (*utang na loob*), and getting along with (*pakikisama*), which were identified among Filipinos in the Philippines during the token use of the Filipino language in Philippine social science by Western researchers and Western-oriented Filipino social scientists in the 1960s, to the Filipino immigrants living in the United States in the 1970s? If culture is dynamic and continues to evolve, are these so-called cultural values demonstrated by Filipinos, which were identified by Lynch (1964) and Bulatao (1964) when they conducted their research in the early 1960s, still applicable to Filipinos who

immigrated in the United States from the 1970s onward? Obviously, the differences in time and location may have created a disparity.

Orque (1983), for instance, suggested that in providing individualized care to the Filipino-American patients, nurses need to be aware of the sociocultural history of the subgroups the Filipino-American patients ethnically identify with in the United States. She claims to be technically a first-generation Filipino-American because she was born in the Philippines. However, the sociocultural history of her immigration to the United States, as someone belonging to the new immigrant group, is different from the first and the second waves of Filipinos who immigrated to the United States in 1765 and in the 1930s respectively. The question to ask, therefore, is how different is she from Filipinos who stayed in the Philippines and had no experience of living in another culture? At least, she cautioned us that some data she cited in 1983 were approximately 20 years old (now 40 years old) and may be applicable only to the first group of Filipino-American immigrants. She therefore advised nurses to make sure that the studies on which they build their asssumptions are "current" and "the findings are applicable to the *specific* (italics hers) Filipino-American group or patient the nurse is serving" (p. 175). The findings of this study show that the characteristics Orque (1983) described of each wave of Filipino immigrants to the United States is not true of Filipinos who immigrated to Canada in the 1960s onward and therefore does not apply in assessing, planning, and providing effective and individualized care to Filipino-Canadian patients.

Filipino Care Values

Transcultural nursing literatures abound with references to these so called Filipino cultural values such as losing face shame (*hiya*), saving face or self-esteem (*amor propio*), debt of prime obligation (*utang na loob*), and getting along with (*pakikisama*) (Orque, 1983; Vance, 1995; Leininger, 1995). According to Enriquez (1977), a social psychologist, this token use still persist in many schools in the Philippines because of the continued use of English as medium of instruction and research in social science by Filipino social scientists. He cited numerous problems in the token use of Filipino psychological concepts in the context of a Western analysis that relies on the English language and English categories of analysis. He pointed out, for example, that "to argue that *utang na loob* is a Filipino value is misleading, to say the least and dangerous at best" (p. 5). He found it convenient for perpetuating the colonial status of the Filipino mind.

Enriquez (1977) also argued that because of what he described as an anomalous situation, even perceptive Filipino social scientist were led to forget that *pakikisama*, for example, is just one among many levels and mode of interaction in Filipino indigenous psychology. He argues that social scientists who unwittingly pluck out the concept of *pakikisama* (getting along with) from the levels of social interaction—*pakikitungo* (amenities), *pakikibagay* (conforming), *pakikipagpalagayang-loob* (mutual trust), and *pakikiisa* (oneness) and then elevate it to a status of value are at the same time supporting (intentionally or unintentionally) the elite and vested interest groups who offers the highest bid for the highly skilled and the most talented. In exchange, they gave as a reward docility, conformity and

Western orientation, which resulted in being opposed to any form of social protest. Enriquez (1977) pointed out that it is not clear if one should accept and identify *pakikisama* as a Filipino value. His contention was that if it is truly a value, why are there many Filipinos who insists on their *pagkatao* (human dignity) and *karapatan* (human rights) and say out right *ayaw kong makisama* ("I refuse to go along")? One who does not want to be involed in any sort of corruption, for instance, is said to be *hindi marunong makisama* (does not know how to go along with). Can this be considered a value? Is this the self-image Filipinos wish to create? Should social scientists perpetuate such an idea? Gorospe (1988), who wrote *Filipino Values Revisited*, is of the opinion that these typical Filipino characteristics or values are not peculiarly or exclusively Filipino. He has argued that they are universal human traits and values found among all peoples, but they receive emphasis in varying degrees in Philippine society.

Filipino Culture Care Constructs

Based on the findings of this study, new insights and new perspective may be applied to Leininger's (1995) general principles for providing nursing care to patients of diverse cultural background. As noted by Dreher and MacNoughton (2002), there are certain qualities that are universal. Being kind, respectful, courteous, approachable, willing to accommodate, and trustworthy were sought and highly valued by Filipino-Canadian patients who participated in this study, but these are not confined to Filipinos. These are also true of other cultures. Regardless, therefore, of cultural background, nurses should show deference, respect, and kindness to patients of all cultural background, age group, and class status. This study confirms that

elderly Filipino-Canadian patients expect not only to be looked up to as authority figures but also to be looked after by family members when they are ill or disabled. It was observed that preference to being cared for in the hospital rather than in the home might be an evolving trend among elderly Filipino-Canadian patients who participated in this study, but they still expect family members to take turns in "watching over" them (*bantay*). This trend is attributed to the fact that family members have to work in order to sustain a high standard of living in Canada.

The involvement of immediate and /or extended family members is integral to the provision of care if the definition of "patient" within the Filipino context includes not only the individual member who is ill but also the whole family. Experiences of Filipino-Canadian patients who participated in this study show that the quality and depth of their relationships with the nurses depend on the nature and levels of interaction and on the patients' willingness to trust and reveal their needs and feelings. I therefore find the emphasis on maintaining nonaggressive relationships with Filipino-Canadian patients, avoiding confrontations and losing and saving face only reinforce the inaccurate description of Filipinos as being concerned only with smooth interpersonal relationships. If the relationships remain unilateral, as demonstrated by patients' difficulty in articulating their needs and feelings, the family members may be the best source of information. They may even act as go-betweens (*tagapamagitan*) or advocates on behalf of the patients.

Privacy has not been associated with quiet times as much as with the "private" parts of their bodies and "personal" information. Filipino patients are, in fact, appreciative of nurses who stay and spend some time talking with them. Gifts in the

form of food are common. Since nurses have already given in the form of service, they are not expected to return a gift that is offered as a symbol of mutual reciprocity.

Filipino-Canadian patients who participated in this study consider life as a gift from God and illness and/or pain as possible punishment but not as a gift. They may, however, identify with the suffering Christ to help them endure pain/suffering. However, to say that Filipino clients can endure more pain than most Anglo- or Jewish-Americans is a unsubstantiated claim and may be a classic use of "religion" to subdue people.

When Leininger (1995) talks about Filipinos, it is not clear whether she was referring to Filipino nurses living and working in the United States or Filipinos she met during her travels in the Philippines. I therefore caution future researchers to compare and contrast groups who live in similar context and within a time frame that are comparable.

Critique of the Method

Challenges in the Use of Language

In doing transcultural research, language plays a major factor. In this study, I was constantly faced with the following questions: (a) Which language should I use during my interviews? (b) If I used Pilipino, would I lose essential concepts in the process of translating the transcript? (c) If I used English, would I lose essential concepts while my participants translated in their minds what they wanted to say? and (d) Which software could accommodate both languages for coding and categorizing my data? When I started my study, I was confident that translation would not be an issue. I speak both languages, and I was assured that most Filipino-Canadians can

speak English and there would be no need, therefore, to include translation in my timeline and costing. In the initial stage of collecting my data, I asked participants to choose either English or Pilipino during the interviews. However, I observed that the mere mention of language made them self-conscious while articulating their experiences in whichever language they selected. There was a point at which I made no mention of making such a choice, and the interviews just flowed spontaneously. Participants would shift to the other language when they found no words to express their thoughts, but the ease helped to get more substance and depth from the interviews.

Overall, the process would have been easier for me if all the interviews had been conducted in English, because I would not have had to worry about translating the transcripts. This took many hours and delayed the analysis stage, but I could not sacrifice quality for speed. I came not only to realize how much our thinking is influenced by the language we use, and vice versa, but also to see the clear connection between language and culture. After frequent shifts from English to Pilipino and back in my speaking, listening, and thinking processes, I realize that meaningful concepts for understanding behavioral patterns within a culture can be identified only in a people's native tongue. How certain was I that I would uncover or discover anything in the process if I limited my interviews to either English or Pilipino? That was the risk I had to take, but it certainly taught me to be open despite the uncertainty I felt while I groped in the complexities of both languages. If I were to do it again, I would have been tempted to use only the Pilipino language, because there is a minimal use of it in research, teaching, and publications, but the reality is

that in transcultural research, one will grapple with two or more languages. I would rather leave it open, because I never know what is out there.

Use of Western Categories

The problem with the token use of Filipino concepts in the context of a Western analysis is that the researcher must rely on the English language, and English categories of analysis are many. In the example given above, Enriquez (1977) argued that such concepts as losing face shame (*hiya*), saving face or self-esteem (*amor propio*), debt of prime obligation (*utang na loob*), and getting along with (*pakikisama*) identified by American and American-oriented Filipino social scientists eventually turned out to be "surface" concepts that were consistent with the Western orientation aimed at perpetuating the colonial status of the Filipinos. He further argued that this could lead to the distortion of the Philippine social reality and the furtherance of the miseducation concerning Filipinos by people from other cultures. He cited, for instance, previous work on Filipino cultural values that illustrates the three "evil" characters in Philippine interpersonal relations:

1. *walang pakikisama*—one inept at the level of adjustment
2. *walang hiya*—one who lacks a sense of propriety
3. *walang utang na loob*—one who lacks adeptness in reciprocating by way of gratitude

He even argued that in proposing the construct of "smooth interpersonal relations" as acquired and perceived through *pakikisama*, euphemisms, and the use of go-betweens, Lynch (1964) and all those who used the same construct in their framework were successful in penetrating and reaching the highest level of interpersonal

relations in the *ibang tao* category, thus giving the impression that *pakikisama* is a value. However, they did not see the importance of other levels of interpersonal relations beyond *pakikisama*, making their observations valid to a certain point but definitely inadequate.

As I pointed out in my review of related literature, *hiya* was interpreted by Fox (1964) as "self-esteem" and by Bulatao (1964) as "a painful emotion arising from a relationship with an authority figure or with society, inhibiting self-assertion in the situation, which is perceived as dangerous to one's ego. It is a kind of anxiety, a fear of being left exposed." In the transcultural nursing literature, Orque (1983), Leininger (1995), and Vance (1995) all used *hiya* as a nursing care construct but did not quite capture that it related more to a sense of propriety than to losing face or being ashamed. They also used the construct of *pakikisama* in explaining Filipino-American behaviors. However, if we easily jump onto any bandwagon or unwittingly pull out concepts and then elevate them to a status of value, we might run the risk of misinterpretation.

Aware of possible pitfalls in the use of such cultural concepts, I was cautious in coding and assigning categories. In retrospect, I conclude that language is both the weakness and the strength of my study. I have to keep an open mind and brace myself to tackle anything that may arise while doing this type of research. Instead of making language an obstacle, it is better to make full use of languages as the main resource.

Implications

Findings of this study imply that culturally sensitive nursing care draws on an understanding of patient-nurse interaction when patients are in hospital. The diversity

of the cultural orientations of the people of Canada implies that nurses and other health professionals are increasingly interacting with others from varying cultural, social, linguistic, and religious backgrounds. Nurses and other health professionals, therefore, must sensitive how culture is affecting the patients' well-being while in the hospital. Neglecting to do so can seriously affect the care of the patients, which can aggravate the hospital experience of the patient and provide additional stress for those who share this experience with them. Findings of this study indicate that these two types of patient-nurse relationship and levels of patient-nurse interaction among Filipino-Canadian patients have significant implications on how care should be provided. The quality of care is evidently demonstrated in our nursing practice. Nursing competence is achieved through a context-based learning. Needless to say, excellence in our continuing nursing education is enhanced by nursing research.

Nursing Practice

The most important implication that arose from this study was the awareness of how the family as the basic social unit and the worldview of *pakikipagkapwa* influence the care of Filipino-Canadian patients in the hospital setting. The nurses and other health professionals have to know who are those considered by the Filipino-Canadian patients as "one of us" (*hindi ibang tao*) and "not one us" (*ibang tao*). For instance, nurses who are assigned to a large hospital unit with Filipino-Canadian patients might find it helpful to know whether their patients are by themselves or are with significant others. Furthermore, if they are with someone, it is important to know their relationship and closeness to the patient; their position in the hierarchical

structure in their family; their knowledge, training, and skills; and their availability to watch over the patient.

Although this study clearly indicates that nurses do not have to be one to take care of one—meaning being "one of us" (*hindi ibang tao*) at the same time as being one with the patient, as in "oneness"—it will not harm nurses if they explore how they can become "one of us" (*hindi ibang tao*). However, in sharing the patient's human identity (*pakikipagkapwa-tao*), the nurses and other health professionals need to strike a balance between maintaining professionalism and at the same time providing personalized care to Filipino-Canadian patients. This can pose a real challenge, as it entails a degree of self-revelation on the part of the nurses and other health professionals. It may even raise ethical questions if exercised to an extent that nurses and patients become over-involved. Although not in all circumstances, it is vital to know that cultural sameness can offer some unique advantage, but in and of itself, it is not sufficient to foster the interaction between the patient and the nurse and to establish effective patient-nurse relationships.

Nurses and other health professionals may also benefit by including and involving family members, relatives, and friends in the assessment, planning, implementation, and evaluation of the nursing care based on the distinctive ways in which families use the concepts of "watching over" (*bantay*) and "caring for" (*alaga*). Relevant to this is the expanded definition of the term patient—based on the Filipino context—that it extends beyond the individual member who is ill to the immediate and extended family. It may even include friends who are considered "one of us" (*hindi ibang tao*).

Another important implication arising from the findings of this study is the attempt to break down the language barriers and to increase cultural sensitivity regarding how the lines of communication are played out among the "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) when caring for Filipino-Canadian patients. This information is essential, for example, in breaking bad news to the patients and their families. There is usually a family member who is recognized as being responsible; it may be the spouse or the eldest among the children. In the case of elderly parents, it is usually the child who sponsored them to come to Canada.

The casual North American way of greeting patients with "Hi, how are you today?" is equivalent to the Filipino pedestrian greeting "Where are you going?" Just as people here are not really interested in knowing how you truly are, Filipinos are not really interested in knowing where you are going. Instead of the usual greeting, however, I suggest that nurses greet Filipino-Canadian patients with "Is there anything I can do for you?" (*Ano ho ang maipaglilingkod ko sa inyo?*) or "How may I help you today?" (*May maitutulong po ba ako?*) In this way, the nurses are opening the line of communication for the patient to say more than just the formal response, "I am fine, thank you" or the casual "pretty good." If patients are alone, I suggest that nurses be very sensitive to the their nonverbal cues. Filipino-Canadian patients give their feelings away with their gazes. Their eyes are certainly very expressive. In addition, if patients who have family members "watching over" them (*bantay*) are unable to articulate their needs or how they feel, it is best to ask their family members what the patients need. As the findings of this study imply, these family members are there to monitor the patients' conditions, needs, care, and treatment. Response to the

two ways of greeting a Filipino-Canadian patient may be indicative of the level of interaction the patient and the nurse have reached and the type of relationship they have established.

Nursing Education

Considering the multicultural context of Canada, more attention should be given to helping nurses acquire knowledge about culture-specific nursing care of patients from diverse cultural background and to develop the skills required to become culturally sensitive and responsive to patients. There is no doubt that the study of different cultures is essential for nurses if they are to gain an insight of the similarities and differences between and among their patients. In addition, there is a need for an understanding of the cultural values, beliefs, and practices that implicitly guide their patients' ways of thinking, acting, and relating. The findings are also of particular relevance in terms of developing an understanding of Filipino identity. In agreement with Dreher and MacNoughton's (2002) contention, the experiences shared by the Filipino-Canadian patients in this study indicate that qualities learned and acquired by student in becoming a nurse are more essential than cultural knowledge and the awareness of similarities and difference between and among peoples of different cultures. These qualities include being kind, respectful, courteous, approachable, trustworthy, and willing to accommodate. Based on what Filipino-Canadian patients who participated in this study expressed as their expectations in terms of the tasks, roles, and responsibilities of family members and nurses, it is implied that *being* a caring nurse (in the real sense of the word) exceeds far beyond *doing* nursing care for the patients.

The major implication arising from this study for nursing education was the need for content on cultural-specific communication techniques and styles to be formally incorporated into nursing curricula. Based on who are considered "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) and the various ways they communicate in the languages of words, gaze, touch, and food, connecting with patients and their families and relatives implies a social sensitivity that Filipino-Canadian patients in this study refer to as *pakikiramdam*—another Filipino value that is prerequisite for sharing human identities (*pakikipagkapwa-tao*). I did not expand on *pakikiramdam* as a Filipino value in the discussion chapter. However, social sensitivity is the ability to perceive the undertones of what is said and/or being receptive to what is unsaid. This is different from making assumptions. Evidently, this has implications for the manner in which communication is taught. Equally important is an understanding of the many variables that determine a nurse's sensitivity to both verbal and nonverbal cues. Steps should be taken to incorporate effective communication skills that are culture specific to enhance the patient-nurse interaction and relationships. Findings of this study also imply the importance of addressing what might constitute the content of nursing curricula and how best to include transcultural care in course syllabi. I recommend, therefore, that even if cultural knowledge is not an essential in giving competent nursing care, more transcultural textbooks reflecting diverse cultures should be written and more articles be published in print and online because they provide good background information and context for understanding the patient's ways of thinking and acting.

Nursing education should provide learning opportunities designed with sensitivity for the cultural context of student nurses in the classroom and their patients in the clinical setting; these opportunities could be developed and implemented with active participation from members who reflect the multicultural nature of society. Knowing what is distinct about different cultures or what is universal can give nurse educators insight into designing nursing curricula, which might help student nurses to reflect on how their own culture and those of others can either enhance or hinder their learning and growth as a nurse and as a person.

Nursing Research

Another important implication drawn from this study is the trust accorded to nurses in particular and to the nursing profession in general. It is evident that without the mutual trust between patients and nurses, and without the generalized trust, the nursing profession loses its authenticity. The experiences of Filipino-Canadian patients show that such trust is therefore not absolute. Trust is conditioned by diversity in beliefs, values, needs, and perceptions at the personal level. As evidenced by the findings of this research, trust is implicit in all levels of nurse-patient interaction, and yet it is readily taken for granted. Trust is obviously the beginning of cooperation, but it is shared human identity (*pakikipagkapwa*) that makes explicit a trusting relationship. Trust is also conditioned by the assurance of competent nursing care obtained from the quality of education provided to nurses. One of the ways for nursing as a profession to guarantee such quality in their education and practice is through research.

Further research is therefore needed among culturally distinct populations living in Canada. The more nurses are aware of the similarities and differences of these cultures, the more prepared and able they will be to deal with the diversity. Findings of this research imply that parallel research with other cultures might be beneficial for regulation and standardization in the practice of nursing.

My findings also suggest the need to explore other Filipino values that are embedded in their health beliefs and practices and to determine how trust is developed and accorded by Filipino-Canadian patients to nurses. There is also a need to explore further the realm of the language of gaze and the language of touch to understand better the nonverbal cues expressed by Filipino-Canadian patients.

CHAPTER 7

SUMMARY

The purpose of this focused ethnography was to uncover culturally embedded values that implicitly guide Filipino-Canadian patients' ways of behaving toward and relating to nurses from other cultures within a multicultural context of Canada and to draw from them concepts that will improve the quality of nursing care across cultures. Data consisted of observation, field notes, interviews, and a personal diary. A purposive sampling of 23 Filipino-Canadian patients who received care in Canadian hospitals participated in the study.

The literature review revealed only a limited number of studies concerning Filipino-Canadians. Although studies concerning Filipinos living in United States are more common than those relating to Filipinos in Canada, few studies have been done concerning their health and illness beliefs and practices, and their health needs and conditions. The literature abounds on Filipino values such as *hiya, amor propio, utang na loob*, and *pakikisama* in formulating culture-specific nursing care. However, there is an obvious need to explore other cultural values, such as *pakikiramdam* (social sensitivity), *tagapamagitan* (the use of go-betweens), *pakikipagkapwa* (shared human identity), and modes of interpersonal relations in the nurse-patient interaction. There is also a need for researchers, especially in the fields of health sciences and nursing, to consider not only the nurses' but also the experiences of nursing care as perceived by patients who are from different cultural background.

The literature defines "culture" as being learned, shared, and passed on from one generation to another. It is a characteristic way of life within which individuals

acquire qualities that distinguish a member of one culture from that of another. It constitutes a particular group's values, beliefs, customs, traditions, norms, and life ways that guide their thinking, decisions, and actions in patterned ways that provide their context—human definitions of life situations. Such common patterns within a given culture define the boundaries of different groups, yet even within a specific cultural group, variations exist based on the degree of acculturation into the mainstream culture. These variations are particularly true of the Philippine culture, described as one with a multiplicity of ethnic groups, each having a distinctive culture, language, and lifestyle.

However, despite their heterogeneity, Filipinos have an identity and a culture of their own that is ever dynamic and evolving. Their personal experiences and awareness of being a Filipino implies identification with the Filipinos as a people—being "one of them." Such consciousness transcends mere empathy and concern. The realization of their Filipino identity becomes evident the moment they encounter people from other cultures or are exposed to television, movies and computers. Their family-centered social structure determines who is *sariling tao* (insider) and *ibang tao* (outsider). Yet, their *kapwa*-oriented worldview enables them to identify other people as being "one of them."

The findings generally reflect the personalistic worldview of Filipinos, which fosters intimacy, warmth, security of kinship, and friendship in all their interactions. It confirms that the family is still the basic unit of social organization among Filipino-Canadians. It serves as the major source of support, especially during illness or crucial moments in their lives, such as births and deaths. The "one of us" (*hindi ibang*

tao) and "not one of us" (*ibang tao*) delineation emerged very distinctly and permeated the Filipino-Canadian patients' prerogative of who performs task or receives information that they consider "personal" and "private."

"Not one of us" (*ibang tao*) is an expression used to refer to "another person" or "other people" who were not members of the family or to people who were from other cultures. Filipino-Canadian patients, however, expected and relied on "one of us" (*hindi ibang tao*), which includes spouses, parents, siblings, and children, to visit, sleep over, and provide care and support when they were in the hospital. More is expected from family members and relatives who are professionally trained as doctors and nurses. Filipino-Canadian patients referred to either the presence or absence of families and relatives during illness or crucial moments in their lives. The presence of family members is manifested by visits and/or sleeping over in the hospital. The level of satisfaction of Filipino-Canadian patients concerning the visits and sleeping over of family members and relatives in the hospital depended on the following: the kind of room they had (private or semiprivate), the type of ward or unit they were in (delivery room, operating room, recovery room, or intensive care unit), and the patients' condition (acute, chronic, or terminal).

The presence of family members is a source of strength for the Filipino-Canadian patients. Some are fortunate to have family members and relatives who are able to come from neighboring provinces of Canada, from the United States, or even from the Philippines to welcome a newborn child into the family, to assist in the care of an ill member of the family, or to console each other when one of them dies. In the absence of family members and relatives, friends from the same culture take their

place. Having to be alone was among the greatest challenges most Filipino-Canadian patients struggled with while in the hospital. Feelings of loneliness, fears and anxieties are some of the reasons that disrupted their physiological functions such as eating, sleeping, and eliminating.

Filipino-Canadian patients expect nurses to be personalized in their approach, especially if the nurses come from the same culture. Kindness, respect, courtesy, being approachable, and willingness to accommodate were important qualities sought by Filipino-Canadian patients from nurses regardless of whether they are from the same or from other cultures. Some Filipino-Canadian patients, however, found some Filipino nurses "disrespectful" and "arrogant" (*suplada*) or "rude" and "discourteous" (*bastos*) and therefore considered them "not one of us" (*ibang tao*), hence the preference for nurses from other cultures. Filipino nurses were generally known to be more serious and devoted to their work than nurses from other cultures.

Most elderly Filipino-Canadian patients have experienced being looked up to as authority figures and are well respected inside and outside the family; therefore, they expected the same regard from nurses whether they come from the same or other cultures. They also experienced being well looked after by family members when they were sick or handicapped and, therefore, expected to be looked after in a similar fashion by nurses from the same or other cultures. Filipino-Canadian patients, however, expected more from nurses who are from the same culture. Further speculation indicated that a parallel treatment might be true of Canadian nurses toward their fellow Canadians. Filipino-Canadian patients used the term *kapwa* to indicate recognition or acknowledgement of a shared identity. When used with the

prefix *pakikipag*, as in *pakikipagkapwa-tao*, it means to have someone share one's identity as a human being. Filipino-Canadian patients used *kapwa* to refer to Filipino and non-Filipino nurses who are able to identify with them on the basis of common characteristics traits or qualitites that make up who they are. It can also be based on common experiences, as in the experience of being immigrants or of being a patient. It is also through *pakikipagkapwa-tao* (shared human identity) that nurses from other cultures become "one of us" (*hindi ibang tao*). Noncompliance to traditional values can lead to conflict and be interpreted as disloyalty. Disagreement, disloyalty, and other negative feelings, such as bitterness among family members and relatives, can dissolve bonds of affinity and consequently bonds of obligation, hence a person becomes "not one of us" (*ibang tao*).

Filipino-Canadian patients classified family members and relatives as private persons and, therefore, considered them "one of us" (*hindi ibang tao*). In contrast, they classified nurses and other health professionals, either from the same or from other cultures, as "not one of us" (*ibang tao*). Findings of this study showed that Filipino-Canadian patients relied totally on members of their family, whom they considered "one of us" (*hindi ibang tao*), and seldom needed assistance from the nurses, whom they considered "not one of us" (*ibang tao*). There were situations where it was difficult to draw a line between the roles and responsibilities of "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*) in the tasks of "watching over" (*bantay*) and "caring for" (*alaga*). However, Filipino-Canadian patients had a distinctive way of using these terms as they described their experiences in the hospital. Filipino-Canadian patients expect "one of us" to assist them in performing

their personal care privately and "not one of us" to provide them with the professional and specialized care.

Findings show that family members and relatives play the roles of personal care providers and go-betweens, whereas nurses assume the roles of professional care providers and givers of comfort. The responsibilities of performing the task of "watching over" were as follows: keeping an eye on the condition of the patients; assisting in their general and direct care; and monitoring their conditions, needs, and treatment. The responsibilities also involved communicating, which included translating, interpreting, and advocating on behalf of the patient. Some of the responsibilities of "not one of us" (*ibang tao*) in the task of "caring for" (*alaga*) included assessing and diagnosing the patients' condition, providing general and specialized care, and monitoring their conditions, needs, and treatments. They also assumed the responsibilities of reporting, recording, and referring patients to the appropriate services. Designation and sharing of responsibilities among those who were considered "one of us" was determined by the individuals' availability, knowledge, training and skills, relationship and closeness to the patient, and position in the hierarchical structure in their family.

Besides being particular about who "watched over" them and "cared for them while in the hospital, Filipino-Canadian patients were also anxious about how they interacted with those who were "one of us" (*hindi ibang tao*) and "not one of us" (*ibang tao*). Excerpts from their stories showed explicitly and implicitly how crucial communication was in maintaining their well-being. The degree of openness and disclosure in communicating, and the depth of interaction in establishing their

relationships, depended on whether the Filipino-Canadian patients considered the individuals "one of us" (*hindi ibang tao*) or "not one of us" (*ibang tao*). This was clearly manifested in varying degree in the different dimensions, from the almost impersonal to the most personal, from the superficial to the deepest and most personal. It was further noted that these cultural values of inclusion and exclusion become much more complex when placed against class variables.

The experiences of Filipino-Canadian patients showed that because of the urgency of the patients' conditions, the intimacy required in doing most nursing care procedures, and the shorter period of hospitalization, patients are placed in situations where they have to interact with nurses without going through the initial levels of formality (*pakikitungo*), adjusting (*pakikibagay*), and acceptance (*pakikisama*) under the "not one of us" relationship. Almost immediately, they find themselves in the subsequent levels of mutual comfort (*pakikipagpalagayang-loob*) and/or oneness (*pakikiisa*) under the "one of us" relationship. It is the willingness of the patient to trust that determines whether the nurses from the same or other cultures are either "one of us" or "not one of us."

Communication is key factor in the nurse-patient interaction. The nurses and other health professionals must familiarize themselves with the Filipino-Canadians' languages of words, gaze, touch, and food. These four ways of communicating are used in support of each other. Seldom are they used in isolation. Because Filipino-Canadian patients have difficulties articulating their feelings, it is important that nurses and other health professionals become familiar with how they use their gaze and touch. The language of gaze and touch are rich sources of nonverbal cues when

interacting and relating with Filipino-Canadian patients. The language of gaze involves the whole facial expression. It includes the forehead, eyebrows, nose, mouth, and how the jaw is set.

The language of touch is important in interactions with Filipino-Canadian patients. Based on how the term is used and factors such as the purpose, depth of pressure, length of physical contact, the stroke applied, the effect it produces, and who is supposed to do it, *hipo*, *haplos*, *himas*, and *hilot*, which generally mean "to touch," connote different meanings. The person who is giving and receiving the touch and the context of how the touch is given and received or reciprocated made a difference in the meaning conveyed by the touch. *Hipo* and *haplos* connote more than just palpating or soothing; they also involves caressing, whereas *himas* and *hilot* are terms that connote comfort, relief, or healing in a more technical sense, as in the traditional bone setting, massage, or even the modern physiotherapy. These terms were also used in a more holistic sense involving not only physical contact but also the emotional component that goes with the touch. Filipino-Canadian patients referred to this as personal touch or human touch, which includes the tone and volume of voice and the attitude expressed by the person touching.

Food is another means identified for socializing among the Filipinos. It has been deemed an appropriate way of communicating gratitude when reciprocity is warranted in a relationship.

Filipino-Canadian patients and their families had spiritual needs while in the hospital. Family members and relatives were usually expected to ensure that spiritual care was provided to them. The spiritual struggles described by Filipino patients

reflected how deep their faith was and how it directed their decisions. It also showed how prayer permeated every dimension of their lives.

Findings of my study also showed that regardless of whether a nurse is from the same or from other cultures, Filipino-Canadian patients consider them "one of us" (*hindi ibang tao*) if they possess qualities such as kindness, respectfulness, courteousness, approachability, and willingness to accommodate the needs of the patients. All of these qualities are essential if one is to achieve the levels of formality (*pakikitungo*), adjusting (*pakikibagay*), and acceptance (*pakikisama*) that are under the category "not one of us" (*ibang tao*). These qualities, therefore, are prerequisites to the level of mutual comfort (*pakikipagpalagayang-loob)* and oneness (*pakikiisa)* under the category of "one of us" (*hindi ibang tao*). In other words, regardless of whether they are from the same culture or from other cultures, nurses qualify as "one of us" (*hindi ibang tao*) if Filipino-Canadian patients find them kind, respectful, courteous, approachable, accommodating, and trustworthy. I therefore conclude that although Filipino-Canadians still uphold strong family ties, as demonstrated by the categories "one of us" (*hindi ibang tao*) and "not one of (*ibang tao*), this does not mean that they cannot accommodate people who are not family members or who are from other cultures. It is the Filipino-Canadian patients' perceptions of the nurses' ability to share their worldview of *kapwa*—the Filipinos

Core value embodied in how they relate with other humans their "beings"—*pakikipagkapwa-tao*—that allows the patient and the nurse to progress in those levels of interaction and therefore become "one of us."

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APPENDIX 1

GLOSSARY OF FILIPINO TERMS

The meanings of most of these words were taken from Jose Villa Panganiban's (1973) *Diksyunaryo-Tesauro: Pilipino-Ingles.* Meanings of Filipino words with a footnote number were taken from other sources. Words preceded by an asterisk (*) and followed by a footnote number have Spanish roots; hence, their meanings were taken from Spanish-Tagalog dictionaries. Words indicated with a double asterisk (**) were colloquial, or words with meanings determined by a particular context.

List of Abbreviations

adj.– adjective

anat. – anatomy

Cf., cf. – compare with the following

colloq. colloquial

indef. – indefinite

interrog. – interrogative

intrj. – interjection

Kpm. – Kapampangan

med. – medical, medicinal

pron. – pronoun

rw. – root-word

Sb. – Sibuhanon, Sugbuhanon (Cebuano)

SL. – Samar-Leyte Bisayan

s.o. – said of

Sp. – Spanish

syn. – synonym(s)

Tg. – Tagalog

v. – verb

Note that the words defined in this glossary are alphabetized according to the Pilipino alphabet, in which c is replaced by k.

ano pron. 1. interrog. what. Cf. *alin*. 2. indef. the thing-whatever-you-may-call-it. Syn. *kuwan*.

alaga n. care, caution.

***amor**[15] Sp. n. esteem, affection. Syn. *amistad, carino.*

–*amor propio* immoderate estimation of one's self.

angal Kpm. Tg. n. prolonged cry, expressing pain, complaint, or opposition.

ari n. property, asset.

–*pag-aari* n. 1. property. Cf. *ari*. 2. colloq. (anat.) one's reproductive organ.

asikaso Sp. (hacer caso) n. attention is given to someone or some task. Syn. *pag-aatindi, pansin; pakikitungo.*

baliwala (from *bale wala*; cf. *bale*) adj. (colloq.) of no value. Syn. *walang-kuwenta, walang-torya, walang-saysya.*

bahala n. 1. responsibility. Syn. *responsabilidad, panangutan, kapanagutan, sagutin.* 2. person responsible, person in charge. Syn. *puno, amo, katiwa, patnugot, direktor, tagapamalaha, manadyer, tagapangasiwa, tagapangalaga,* 3. Management. *maneho, pamamahala, direksyon, pamamatnugot, administrasyon, pangangasiwa, liderato, pamiminuno.*

–*Bahala ka na* You look out and be responsible when the time comes.

–*Bahala na* We'll consider what to do when the time comes.

bantay[16] n. guard.

bastos adj. 1. vulgar, crude, coarse. 2. indecent, lewd (s.o. person, actions).

bayani , ***bayanihan*** n. cooperative endeavor, mutual aid. Syn. *tulungan, usungan, damayan.*

–*Bayanihan* n. cooperative endeavor in community development.

bilin n. 1. errand (asked to be done). Syn. *pagawa.* 2. order, command. Syn. *utos, atas, orden, mando.* 3. instructions, directions (given by one leaving for a time). Syn. *instruksyon, patupad, tagubilin.* 4. request. Syn. *pakiusap, pamanhik.* 5. counsel, advice. Syn. *konseho, payo*; cf. *paalaala, pagunita, tagubilin.* 6. last will and testament. Syn. *huling habilin, testamento.* 7. something left in another's charge. Syn. *habilin, paingat, lagak, deposito, iwi, paiwi.*

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[15] Oficina de Educacion Iberoamericana. (1972). *Hispanismo en el Tagalog.* Madrid.
[16] Bickford, S. & A. (1985). *Pilipino-English, English-Pilipino: Concise Dictionary.* New York: Hippocrene Books.

kapatid (rw. *patid*) n. brother, sister. Syn. *Atid, utol, kaputol, manong, manang*; cf. *kaka, kuya, ate.*

–*kapatiran* n. brotherhood, fraternity; sisterhood, sorority.

kami pron. we (excluding person or persons addressed). Syn. *Tayo, kata*; cf. *amin, natin, atin, natin, ata, nata, ta.*

–*kami-kami lamang* only (for) us members of our group (no outsiders).

–*kami lamang* only us.

kapuwa var. ***kapwa*** pron. 1. both. Cf. *ang dalawa, pareho*. 2. fellow being.

–*kapuwa tao* fellow human being.

kuwan Sp. (cual) pron. what-you-may-call-it, thing (a word used for whatever one cannot immediately or exactly express, but may usually be understood). Syn. *ano.*

(damay) *pagdamay* n. joining and helping sympathetically. Syn. *pagtulong, pag-aabuloy, pag-adya, pagsaklolo, pagdalo.*

–*damayan* 1. n. mutual aid. Syn. *tulungan*; cf. *kooperatiba*. 2. v. to give sympathetic aid to, or express feeling of sympathy and condolence for (x).

haplos, *paghaplos* n. gentle or soft act of rubbing on skin surface for the relief of pain or as a caress. Syn. *Masahe, himas, hagpos*; cf. *kuskos.*

–*haplusin ang masakit na batok.* massage the painful nape of the neck.
–*panghaplos* n (med.). liniment or ointment used in massaging.

hilot 1. n. (med.) midwife. Syn. *komadrona*. 2. *paghilot* n. Sb.SL.Tg. massage. Syn. *masahe, hagod, haplos, himas*; cf. *kuskos, lamas.*

–*hilutin* v. to massage (x). Syn. *masahihin.*
–*ipahilot* v. to get someone to massage (x).
–*maghilot* v. to massage.
–*panghilot* v. to practice midwifery.
–*panghilot* n. matter used in massaging.

himas, *paghimas* n. 1. gentle rubbing on skin by the palm of hand. Syn. *hagpos, haplos, hilot, hagod, masahe.* 2. caressful rubbing; cf. *lambing, lamyos*. 3. petting by rubbing the feathers of roosters or the fur of dogs, cats, etc.

hina, kaninaan n. 1. weakness of body. Syn. *tamlay, pagkakalay, lambot ng katawan, hinay*, 2. Slowness of speed. Syn. *dahan, dalang, bagal, kupad, hinay*. 3. Lowness or weakness of sound pitch. Syn. *baba ng tunog, baba ng tinig, baba ng nota sa iskala*; cf. *anas, bulong, piyanisimo*. 4. dullness or slowness of business, sales, or monetary movement. Syn. *bagal ng pananalapi, mahinang benta, dalang ng mamimili*. 5. Lack of intensity or force. Syn. *hinay, walang-lakas, walang puwersa, kulang sa lakas, kulang sa puwersa, dimalakas, panghihina*.

–*mahina* adj. weak, slow, dull, frail. Cf. *nanlambot, nanghihina*.
–*Maniha ang katawan* the body is weak.
–*panghinaan ng loob* to be discouraged, lose interest or enthusiasm.

hindi no, not.

hipo, paghipo n. touch, touching; palpation. Syn. *salat*; cf. *kapa, apuhap, dama, damdam, himas, hagpos, haplos, kalabit (kublit), tapik*.

–*hipuan* v. to touch the delicate parts of (x).
–*hipuin* v. to touch (x).
–*humipo* v. to touch.
–*pahipo* v. to allow self to be touched.

hiya n. shame, embarrassment, timidity.

–*mahiyain* adj. diffident, timid, bashful.
–*nakakahiya* adj. embarrassing, shameful.
–*nahihiya* v. feeling timid.
–*walan-hiya* adj. shameless.
–*walang-kahiya-hiya* adj. completely bereft of shame.

iba 1. pron. other. 2. adj. another; different.

–*ibang tao* another person, other people. It assumes that one is different from the other.

lakas. n. 1. Kpm. Tg. strength, vigor. 2. efficacy. Syn. *bisa, epikasya*. 3. vehemence. Syn. *bagsik, sidhi, silakbo*. 4. (applied to sound) loudness. Syn. *lakas ng tunog, ingay, linggal*. 5. (applied to health of body) healthiness. Syn. *lakas ng katawan, kalusugan, tipuno*. 6. (applied to fever) highness of temperature. Syn. *lakas ng lagnat, taas ng lagnat*. 7. (applied to attack of sickness) intensity. Syn. *lakas ng atake, sikal, sasal, sidhi*. 8. (applied to will or spirit) daringness, fearlessness. Syn. *lakas ng loob, tapang, kapangahasan*. 9. power, might. Syn. *kapangyarihan, poder*. 10. Influence. Syn. *impluensya, impluho*.

–*malakas* adj. strong, vigorous, intense.

lagay *kalagayan* n. 1. position, situation, circumstances. Syn. *puwesto, estado, sitwasyon, tayo, katayuan, katatayuan, sircumstansya* 2. condition. Syn. *kondisyon* 3. appearance. Syn. *itsura, anyo* 4. unit of size or number. Syn. *yunit, lote, huwego, terno*. 5. (colloq.) bribe, inducement, tip. Syn. *pabagsak, tip, suhol*. 6. Bet in gambling. Syn. *taya, pusta*.

–*kapalagayang-loob* n. intimate, confidant, trusted friend. Syn. *katapatang-loob*.
–*lagay ang loob* confidant. Syn. *panatag, nagtitiwala, tiwasay, palagay-loob*.
–*lagay ng loob attitude* state of mind. Syn. *kalooban, saloobin, hilig ng loob*.
–*maglagay* v. 1. to put. 2. to give a bribe. Syn. *sumuhol*.
–*magpalagayang parang magkapatid*. to treat each other like brothers and sisters.
–*palagay* n. opinion, idea, surmise, supposition. Syn. *isip, akala, idea, hinuha*.

loob *kalooban* n. Tg. 1. interior, internal part, the inside. 2. courage, valor. Syn. *tapang, sahang, giting*. 3. will, volition, state of mind. Syn. *buluntad, bulisyon, lagay ng loob*.

–*Ano ang nasa loob mo*? What is in your mind?
–*kaloob* n. something granted or awarded.
–*kusang loob* 1. adj. voluntary. 2. n. initiativeness.
–*isaloob* v. to bear (x) in mind.
–*lakas nang loob* n. courage, valor, intrepidy.
–*may loob* adj. brave, courageous
–*Napasaloob kong tawagin ka*. It occurred in my mind to call you.
–*sa loob* adv. inside.
–*saloobin* n. attitude of mind
–*pagkalooban* v. to grant (x) something
–*tigas nang loob* Hardiness in valor

Naku! Intrj. from *Ina ko!* direct translation of the Sp. *Madre mia*!
Note: Naku! Is said to have replaced the old call to Allah popular before the coming of the Spaniards to the Philippines. Some folklorists consider *Ala ahoy* of the Batangeunos as vestige of the Muslim ejaculation.

paki- pref. forming nouns, with the *ki-* syllable doubled, denoting manner of or continuing act of *paki-*. Transformed from the present tense form of *maki*-verbs. Also denoting accompanying or joining in action.

–*pakikibagay* n. conformity. Syn. *pakikiayon*.
–*pakikiisa* (rw. *isa*) n. one. v. to join in the unity of thought or action. Syn. *makipagkaisa* to join in a cooperative and unified endeavor; *makipagkasundo, makisama*.
–*pakikilahok* (rw. *lahok*) 1. n. participation, entry. 2. v. to particiapte. Syn. *sali, kakompetensiya*

–pakikisalimuha (rw. *sali*) *–kasali* n., adj., person included as partaker or participant. Syn. *kasama*. Cf. Tg. *kaayon*.

–pakikisama (rw. *sama*) – *kasa-sama* n. frequent or constant companion. *–kasama* companion. Syn. *kapisan*, *kasambahay*, *kaabay*, *katabi*, *kasiping*. 1. v. to join. 2. n. companionship; manner or attitude of getting along with others.

–pakikisangkot (rw. *sangkot*) – *mapasangkot* v. to be dragged into, be implicated in, an affair or trouble. Syn. *mapasama, maparamay, madalakit*. Cf. Tg. *makaayon*.

–pakikitungo (rw. *tungo*) – *pagtungo*, *patungo* n. direction of going, manner of dealing with. Syn. *tugpa*, *tumpa*, *punta*.

paki- pref. forming nouns, with *ki* reduplicated and the infix *-pag-* making the compound pref. *Pakikipag-*, denoting accompanying or joining in an intense action of continuing manner. Transformed from the present tense of *makipag-* verbs.

–pakikipagkapuwa[17] n. social intercourse; consideration for others.

paki- pref. forming nouns, with *-an*, *-han*, *-nan*, producing the bilateral affix *paki...an*, denoting request for something to be done to, on, or for (x: the subject).

–pakiramdaman (rw. *dama*) var. *nadarama* 1. adj. felt, perceived, sensed. Syn. *damdam*, *pakilasa*. 2. n. feeling, understanding feeling.

paki- pref. forming nouns, with *ki* reduplicated and the infix *–pag-* and the suffix *-an* (*-han, -nan*), making the bilateral affix *pakikipag...an*, denoting a continuing act of accompanying or joining in some intense reciprocal action. Transformed from the present tense of *makipag...an* – verbs.

–pakikipagpalagayang-loob n. comradeship, friendship.

sarili pron. self. adj. one's own, private (not public).

–sariling tao one's own people

suplado Sp. (soplado) adj. swelled-up (in manners); conceited; cf. *hambog*, *palalo*, *mapagmataas*; *mapagpasikat*; *makaako*.

taga- prefix expressing "occupation."

tagapag- prefix denoting the person whose duty is what the rw. says. Syn. *taga-*.

tagapamagitan (rw. *pag-itan*) n. go-between, intermediary, contact man. Cf. colloq. *kontak*.

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[17] De Gusman, M. O. (1966). *English-Tagalog and Tagalog-English Disctionary*. Manila, Philippines: National Book Store, Inc.

tayo pron. we (all inclusive). Cf. *kami*, *kata*.
–*tayong lahat* all of us.
–*tayu-tayo lamang* exclusive to us, we alone (us alone).

utang *pautang* n. loan, money lent. Syn. *pahiram*, *prestamo*.

–*utang na loob n.* debt of gratitude.
–*kumilala nang utang na loob* v. to acknowledge a debt of gratitude.
–*walang utang na loob* adj. ungrateful. Syn. *ingrato*.

APPENDIX 2-A

INVITATION TO PARTICIPATE IN A RESEARCH STUDY

(For newsletters, newspapers and radio station advertisement)

You are invited to participate in a study on the Filipino patients' experiences of being care for by nurses from another culture. The purpose of this study is to improve nursing care in a cross-cultural setting. Please be assured that whatever you share in the interviews will be completely confidential. While each response is very important, findings will report overall patterns rather than individual responses.

To participate in this study you should meet the following criteria:

- first-generation Filipino male or female adult immigrant, born in the Philippines
- have lived in Canada less than ten years
- eighteen years of age and above
- have been hospitalized in a Canadian hospital in the past ten years

Thank you for your cooperation and time.

Sincerely,

Alberta Catherine Y. Pasco, R.N. MPA

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APPENDIX 2-B

PAANYAYA UPANG MAKIBAHAGI SA PANANALIKSIK

Malugod kayong inaanyayahang makibahagi sa isang pag-aaral hingil sa: mga Pilipinong pasyente at ang inyong mga karanasan nang kayo ay inalagaan ng mga nurs na nakaka-ibang kultura. Ang pag-aaral na ito ay higit na makakatulong upang pagbutihin ang pag-aalaga ng mga nurs sa mga pasyente na iba-ibang ang Kultura. Umasa kayong ang anumang pinag-usapan sa pakikipagpanayan ay mananatiling "CONFIDENSYAL" at hindi gagamitin sa ibang dahilan maliban sa pag-aaral na ito.

Upang matanggap na kalahok sa pag-aaral na ito, ikaw ay kinakailangan tumataglay ng mga sumosunod na kataingia:

- unang-henerasyong Pilipino babae or lalaki na pinanganak sa Pilipinas
- nakatira sa Edmonton nang higit kumulang sampong taon
- labing-walong gulang o higit pa
- nakaranas na namatanggap sa loob ng hospital sa loob nang sampong taong naninirahan sa Edmonton

Kung kayo ay nagnanais na makilahok at maging bahagi na pananaliksik na ito huwag kayong mag-atubiling tumawag kay Bb. Alberta Catherine Pasco sa 492-9100 Tanggapang ng Mataas na Paaralan ng Pagiging Nurs sa Unibersidad ng Alberta o di kaya'y sa 492-8778 Tanggapang ng Kuwalidad o Ma-uring Paraan ng Pananaliksik.

APPENDIX 3-A

INFORMED CONSENT TO PARTICIPATE IN THE STUDY

Part 1 (to be completed by the Principal Investigator):

Dear _____,

My name is Alberta Catherine Y. Pasco. I am a graduate student of the Faculty of Nursing at the University of Alberta. I am conducting a study on the Filipino patients' experiences of being cared for by nurses from another culture. This study will help nurses improve their nursing care in a cross-cultural setting. If you agree to participate in this study, the researcher will arrange to visit you at your home on a day and time most convenient for you. If, at any time during the visit and the interview, you feel you do not wish to answer any of the questions you are free to do so. You have the right to drop out of the study at any time you choose.

It is important that you feel comfortable and free sharing your experiences, thoughts and beliefs with me. I would be very happy to answer any questions or concerns you may have concerning the study or any of its procedures. I would like to record our conversations on tape if you do not object. Taping will allow me to listen and freely interact with you instead of being busy taking notes. The tape-recorded interviews will be destroyed at the end of the research project, or at any other time, at your request. Your responses will be kept confidential. Code numbers rather than names will be used during the transcription. Your signed consent form with the code numbers will be securely locked in a filing cabinet.

Any publications from this study will not identify individuals and upon request a summary of the results of this study will be provided for you. At the completion of our final interview, I will ask you to introduce me to your relatives and friends who may wish to participate in this study.

Thank you,

Alberta Catherine Y. Pasco

Part 2 (to be completed by the research participant)

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your job in the community?	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you understand who will have access to your records?	Yes	No

This study was explained to me be: _____

I agree to take part in this study.

_____ _____ _____

Signature of Research Participant Date Signature of Witness

_____ _____

Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agree to participate.

_____ _____

Signature of Investigator/Designee Date

The information sheet must be attached to this consent form and a copy given to the research participant.

APPENDIX 3-B

KASUNDUAN MAKIBAHAGI SA PAG-AARAL
Pag-aaral Hingil sa Mga Pilipinong Pasyente at Ang Kanilang
Mga Karanasan Nang Sila Ay Inalagaan Ng Mga Nurs Na Nakaka-ibang Kultura

Unang Bahagi:
Mahal kong Bb./Gg._____:

Ang pangalan ko ay si Bb. Alberta Catherine Y. Pasco. Ako ay kasalukuyang nag-aaral sa Mataas na Paaralan ng Pagiging Nurs ng Unibersidad ng Alberta. Ako ay malugod na nasisiyahan sa inyong pagpaunlak na makibahagi sa pag-aaral hingil sa mga karanasan ng mga Pilipinong pasyente nang sila ay inalagaan ng mga nurs na nakaka-ibang kultura. Ang pag-aaral na ito ay higit na makakatulong upang pagbutihin ang pag-aalaga ng mga nurs sa mga pasyente na iba-ibang ang kultura. Kung kayo ay sumasang-ayon na makilahok at maging bahagi na pananaliksik na ito, aayusin ng mag-aaral na siya ay dumalaw sa inyong tahanan at makipagpanayam sa inyo sa araw at oras na pinakamainam sa inyo. Kung sakasakaling magbago ang inyong isip hingil sa pakikibahagi o di kaya'y hindi ninanais sagotin ang ano mang tanong ng mag-aaral, kayo ay malayang umiwas sa pagsagot o umurung sa ating kasunduan na lumahok sa pag-aaral na ito.

Mahalaga na malaya at mapalagay ang inyong kalooban sa pagbabahagi ng inyong mga karanasan, kuro-kuro at pananalig sa akin. Malugod kong sasagotin ang anomang katanungan hingil sa pag-aaral o paraan ukol sa pakikipagpanayam na ating gagawin. Ninanais kong ilagda ang ating pakikipagpanayam sa *tape* kung kayo ay sasang-ayon. Ang paglagda nang ating pakikipagpanayam sa isa't isa ay makakatulong sa aking malayang pakikinig samantalang kung ako ay abalang nagsusulat nang anumang inyong sinasaad maaring mahati ang aking atensyon. Lahat na nailagdang pagkikipagpanayam sa *tape* ay buburahin or sisirain pagkatapos ng pag-aaral na ito o anumang oras na pagpasya kayong umurong sa ating kasunduan. Umasa kayong pag-iingatan ko ang inyong pananalig na anumang ating pinag-usapan ay mananatiling lihim o "CONFIDENSYAL" at hindi gagamitin sa ibang dahilan maliban sa pag-aaral na ito. Mga nakalaang bilang ang gagamitin sa bawat nakalagdang pakikipagpanayam. Ang papel na inyong nilagdaan upang makilahok sa pag-aaral na ito at kung saan nakasulat ang nakalaang bilang ay itatago sa nakasusing lalagyan.

Ang anumang paglalahad hingil sa kinalabasan ng pag-aaral na ito ay hindi tataglay ng sinumang pangalan ng mga nakilahok. Maaasahan din ninyong magkaroon nang copya ng kabuuhan ng kinalabasan ng pag-aaral na ito. Pagkatapos ng ating pakikipagpanaam sa isa't isa inaasahan kong ipakilala ninyo ako sa inyong mga kamag-anak o kaibigan na nagnanais na makibahagi sa pag-aaral na ito.

Taos pusong nagpapasalamat,

Alberta Catherine Y. Pasco

Ikalawang Bahagi: Naunawaan po ba ninyo na kayo ay inaanyayahang makibahagi sa isang pag-aaral? Oo Hindi

Nakatanggap at nabasa na po ba ninyo ang sulat nang mag-aaral na nagsasaad ng kanyang pananaliksik? Oo Hindi

Naunawaan po ba ninyo ang ikabubuti at maaaring panganib sa pakikilahok sa pananaliksik na ito? Oo Hindi

Nagkaroon po ba kayo ng pagkakataon na magtanong o pag-usapan ang anumang katanungan o pag-aatubili sa paglahok sa pag-aaral na ito? Oo Hindi

Naunawaan po ba ninyo na malaya kayong tumutol o umurung sa kasunduan makibahagi sa pag-aaral na ito anumang oras na inyong mapagpasyahan? Hindi kinakailangan magbigay nang dahilan at hindi rin kayo malalagay sa alanganin sa anumang samahan? Oo Hindi

Napaliwanag po ba sa inyo na pag-iingatan nang mag-aaral ang inyong pananalig na hindi gagamitin ang anumang inyong pinag-usapan sa ibang dahilan maliban sa pag-aaral na ito at hindi rin tataglay ng sinumang pangalan ang paglalahad hingil sa kinalabasan ng pag-aaral na ito? Oo Hindi

Naunawaan po ba ninyo kung sino ang maaaring makinig at magbasa nang mga nailagdang pakikipagpanayam? Oo Hindi

Itong pag-aaral na ito ay pinaliwanag sa akin ni Bb. _____.

Sumangsangayon akong makilahok at makibahagi sa pag-aaral na ito.

_____	_____	_____
Lagda nang Nagnanais Makilahok	Araw ng Paglagda	Lagda nang Tistigo

_____	_____
Nakasulat na Pangalan	Nakasulat na Pangalan

Nananalig ako na ang taong naglagda nang kanyang pangalan sa kasunduang ito ay may pagunawa kung ano ang nakasalalay sa makikibahagi sa pag-aaral na ito at malayang sumasangayon na makilahok at makibahagi sa pag-aaral na ito.

_____	_____
Lagda ng Mag-aaral o Mananaliksik	Araw ng Paglagda

APPENDIX 4

DEMOGRAOPHIC COLLECTION SHEET

1. Code Number _____ Name _____

Age _____ Gender _____ Marital Status _____

Religion _____ Languages & Dialects spoken _____

Educational Background _____Occupation _____

Income _____When did you migrate to Canada? _____

Where in the Philippines did you come from? _____

Where in the Philippines are your parents from? _____

Remarks:

Health Research Ethics Board biomedical research health research

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UNIVERSITY OF ALBERTA HEALTH SCIENCES FACULTIES,
CAPITAL HEALTH AUTHORITY, AND CARITAS HEALTH GROUP

HEALTH RESEARCH ETHICS APPROVAL

Date:	May 2001
Name of Applicant:	Ms. Alberta Pasco
Organization:	University of Alberta
Department:	Graduate Studies; Nursing
Name of Supervisors:	Dr. Janice Morse & Dr. Joanne Olson
Organization:	University of Alberta
Department:	Nursing
Project Title:	Being Cared for by Nurses from Another Culture: The Experience of Filipino Canadians in Edmonton

The Health Research Ethics Board has reviewed the protocol for this project and found it to be acceptable within the limitations of human experimentation. The HREB has also reviewed and approved the subject information material and consent form (if applicable).

The approval for the study as presented is valid for one year. It may be extended following completion of the yearly report form. Any proposed changes to the study must be submitted to the Health Research Ethics Board for approval.

Sharon Warren

Dr. Sharon Warren
Chair of the Health Research Ethics Board (B: Health Research)

File number: B-090401-NSG